

# **America's Health: Recent Trends in Health Care**

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## Summary

The health care system in the United States has changed substantially in recent decades. We have increased our spending on health care, both in absolute terms and as a relative share of total spending. The methods of delivery of health care, technological capabilities, demographics, and the sources of payment for health care expenditures have also changed a great deal. This research memorandum examines recent trends in three sectors of our health care system: the private insurance sector, Medicare, and Medicaid. The creation of Medicare and Medicaid in 1965 has had a strong influence on our health care system, and the private insurance market for health care coverage has changed considerably as well. To date, efforts to slow the rate of growth of health care costs have focused on cost containment methods to limit utilization, and have not addressed the implications of structural changes in society and our health care market.

In the private market, growing insurance costs squeezed the growth of wages, as firms found the cost of providing health care benefits rapidly increasing. In an effort to deal with the rising costs of health insurance, and to remain competitive in the international market, it became important to slow down the growth of health care costs. Insurers and employers focused efforts to control costs on:

- Shifting more direct costs to consumers
- Diverting care to lower cost methods
- Restricting patient choice of services
- Limiting intensity of use of services.

The shifts taking place in the private insurance market are rapidly changing the patterns of health care provision in the United States. Starting in the 1980s, insurers and employers made various alterations to the private insurance market, generally moving in the direction of managed-care initiatives. In 1981, health maintenance

organizations (HMOs) made up only 5 percent of the nation's private insurance market; the other 95 percent fit the category of traditional (fee-for-service) insurance. By 1990, however, 20 percent of the insurance market was represented by HMOs, with an additional 5 percent described as HMO-plus, or point-of-service (POS). Only 5 percent of the market remained as traditional insurance. The remainder had shifted to variations of managed care.

Hospital admission rates have declined as have hospital occupancy rates and patient days in the hospital. Evidence also indicates that the high rates of growth of premiums for private insurance have begun to slow. Although changes are still occurring, for the moment the basic nature of private insurance has responded to attempts to deal with the issue of rising costs. Various methods of cost containment have been instituted, and new methods are still emerging. There has been some success at changing the nature of the private insurance process. Beneficiaries have a better understanding of health costs and issues, and the rapidly rising costs for health care have slowed.

Turning to the government side, we see that since 1965 Medicare has assumed a very important role for the elderly as the primary health insurance for those above age 65. Although Medicare plays a crucial role, seniors still pay for a substantial share of their health care costs, either through direct payments or by purchasing MediGap insurance in the private market. The growth of Medicare spending has been relatively smooth over time and has reflected the constantly (although slowly) increasing numbers of those above age 65, as well as the relatively high growth in recent years of the medical component of the consumer price index. The expected continuation of the aging of our population, especially when the baby boomers reach age 65, will stress our society's ability to pay for Medicare in coming years.

During efforts to balance the national budget, Medicare becomes an attractive target for cuts because it represents a large (and growing) pot of money. However, Medicare has a strong constituency: those who depend on Medicare are politically active and well organized. Managed care has been suggested as a way to trim the growth of Medicare costs. Given the strength of support for traditional Medicare, it appears likely that *voluntary* enrollment in HMOs will be encouraged for seniors. If seniors do not respond to incentives to join HMOs, or

if the initial managed-care efforts do not yield desired savings, Medicare may face more substantive policy changes in the future.

Compared to Medicare, Medicaid has had a volatile history. The program has been modified in a number of ways since 1965, with eligibility changes being turned on and off. At times, categories of people have been added to the list of mandatory coverage. At other times, the requirements have limited eligibility. As a result of all these changes, as well as the general growth in medical costs, the upward trend of growth in Medicaid spending has followed a uneven path, sometimes changing significantly from year to year. In addition, in recent years Medicaid has absorbed spending for some very high cost groups of eligibles—the elderly poor and the disabled.

The current austere budget climate is likely to result in changes to Medicaid. Experimentation with small Medicaid demonstration projects for alternative methods to deliver health care services is giving way to tentative plans to place most Medicaid recipients in managed-care systems. Block grants to the states would allow each state to devise and manage its own system, with an overall incentive to put Medicaid recipients into HMOs.

For the government, the growth of Medicare and Medicaid spending poses problems at the federal and state levels. Our society has scarce resources to allocate, and the growth of these two programs strains our allocation of government spending. To blame our nation's deficit spending on the growth of Medicare and Medicaid is inaccurate: many programs have contributed to our national debt.<sup>1</sup> However, continued high growth in Medicare and Medicaid spending runs counter to efforts to eliminate deficit spending. In the private insurance market, high growth in the cost of insurance coverage has increased employee benefit costs, squeezing the growth of wages and making it more difficult for employers to provide comprehensive health coverage for their employees.

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1. Medicare and Medicaid account for roughly 9 percent and 5 percent of federal spending, respectively, as of 1993.



One common theme of the major federal programs, Medicare and Medicaid, and the private insurance market, is the recognition that health care cost increases are straining our economy. Government costs are straining our ability to tax and pay for health care for the elderly, poor, and disabled, and private costs are straining employers' ability to provide health insurance to their employees and still offer decent wage increases. A second theme is that both the public and private sectors are using a variety of cost-containment measures that focus on curtailing utilization to try to slow the growth in health care spending. Although we see initial success in certain areas, such as declining hospital admission rates, it is not clear whether we have brought the process under control in any long-term sense. We have not focused on long-run structural issues, such as how new technological capabilities and changing demographics (our aging population) are contributing to our health care costs.

# Introduction

The U.S. health care industry has flourished during the past 30 years. In nominal terms, personal health care expenditures have increased from \$23.9 billion in 1960 to \$727.1 billion in 1992. This increase reflects an average annual rate of change of 11.2 percent in personal health care expenditures [1], compared to an overall average annual growth rate of about 5 percent as measured by the Consumer Price Index (CPI). As it has grown, the industry has changed. In 1960, the primary providers of health care services were physicians and hospitals. Most people paid for their health care directly out of pocket on a fee-for-service basis, and the government was not a major purchaser of health care services.

In the 1990s, the health care system includes a growing number of nonphysician providers, and a large percentage of health care services are provided on an ambulatory basis rather than through the once-traditional inpatient hospital setting. Most people rely on private or public insurance programs to pay for their health care. Managed care strategies focusing on utilization and costs have become an integral part of our health care system. The industry is cluttered with acronyms—HMO, PPO, PPS, DRG, RBRVS, PCM, PRO—reflecting a mixture of policy and market innovations that have materialized along the way. How did we get here? And what direction might the health care industry take in the near future?

Part of the answer involves American values and how we finance our health care system. These factors represent formidable forces within the system. Americans tend to favor free market principles. We view government intervention suspiciously and only grudgingly acquiesce to regulatory actions as a means to “correct” economic and social aberrations. As a nation, we repeatedly struggle with the issue of how much government intervention in any particular area is justifiable and whether such action should be at the national, state, or local level. We debate, quite contentiously, the issue of how much the gov-

ernment should be involved in determining the structure of our health care system. In [2], Lawrence Brown notes that “the 1990s find a health care system that is both increasingly competitive and more heavily regulated but that obeys no broad conceptual blueprint on either front.”

## Objective

Our purpose in this paper is to examine recent trends in the evolution of the American health care system.<sup>2</sup> We intend to establish a baseline against which we may assess the state of the industry today and from which we may posit hypotheses concerning the near-term future. We are also interested in the role of the market and the government in this evolution. How have market forces and government regulation affected the evolution of the health care industry? Where does the industry stand now in terms of market and government forces? What might we expect in the future?

## Organization of document

We structure our analysis within the context of the three predominant sources of health care financing during the past 30 years: private coverage (either employer-based or individually purchased) and the two public behemoths in health care—Medicare and Medicaid.<sup>3</sup>

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2. We will not, however, address the issue of national health care reform and efforts to provide universal coverage. We have considered this topic in detail in another paper [3].
  3. Medicare and Medicaid are only two of many health-related programs under government sponsorship. Government funds support many health services programs and activities. A good portion of this funding purchases health care services through programs, such as the Veterans' Health Administration, the Public Health Service, and the Indian Health Service. Federal dollars also support medical research, such as that done at the National Institutes for Health, and the construction of medical facilities. However, Medicare and Medicaid are the largest of all public health programs. Since 1970, they consistently have made up about two-thirds of total national public health expenditures (see [4, table 148, p. 111]).

We begin our analysis with a brief history of the evolution of popular acceptance of health insurance in both the private and public sectors in the United States. We focus particularly on the time period between 1945 (the end of World War II) and 1965 (the beginning of Johnson's Great Society).

In the next section, we discuss the transition of the private sector of the health care industry to managed choice. In the early 1960s, most medical expenses were paid for directly by consumers, on an out-of-pocket basis. The growth of private insurance, and of public insurance, erected barriers between the consumer and the provider of health care services. Those seeking health care services became less likely to actually pay the bills; the providers were reimbursed by the government or by private insurers. This creates a system in which the consumers have a lessened incentive to be cost conscious and do not seek out information to use in making decisions about health care purchases.

Over time, the rapidly rising costs of health care in the private sector have affected insurers. Employers and health care consumers, in turn, face higher premiums and costs. We examine the steps taken by the private market to institute cost-control mechanisms, and we observe the responses of the private health care market to these initial cost-control measures. Information available to individual customers is limited, so insurers have taken on part of the burden of seeking out information regarding cost-efficient provision of services.

Next, we provide an overview of the U.S. public health insurance system, focusing on Medicare and Medicaid. These two programs are part of a social safety net, serving as a remedy for the shortcomings of the private market to provide coverage of health expenses for certain vulnerable populations. Both are entitlement programs. As these programs have grown in size in terms of eligible beneficiaries and dollars expended, they have acquired an important role in shaping our health care industry. We examine how Medicare and Medicaid programs have served as mechanisms through which the federal government has influenced system norms within the U.S. health care industry. Essentially, we find a system in which dual pressures for program expansion and cost containment have created competing interests. In response, Congress has adopted regulation to relieve federal financial pressures

on the Medicare and Medicaid programs and has effectively permitted providers to shift costs to other purchasers.

Finally, we conclude with a section that pulls together the trends and themes in public and private health insurance programs. How have the private and public health sectors interacted and influenced each other? What may we learn from these patterns concerning the future of the U.S. health care industry? And given recent dynamics, what changes, if any, may we expect in the future?

# Background

## Private health insurance

Popular acceptance of private health insurance in the United States grew out of the New Deal policies of the Great Depression. In 1942, the War Labor Board decided that employer-provided health insurance coverage for workers did not represent a violation of wage controls. As collective bargaining expanded after World War II, employee health insurance coverage became a negotiable item. In the late 1940s, President Truman proposed a comprehensive national health insurance plan, which the American Medical Association (AMA) successfully opposed [5]. As a consequence, workers and their dependents became the predominant beneficiaries of health insurance coverage.

Initially, health insurance plans offered coverage of inpatient hospital care and gradually expanded over time to include physicians' fees and other hospital services. Blue Cross provided insurance based on a community rate set for a particular geographic area. Commercial insurance companies, on the other hand, sold benefit packages to individual companies. They set premiums based upon the experience rating for the particular company. Companies with younger and healthier employees generally received better ratings and lower premiums.

Competition with the commercial companies led Blue Cross to switch to experience rating in order to avoid losing healthy, low-cost groups [6]. The proportion of all workers with hospitalization coverage increased from 49 percent in 1950 to 74 percent in 1965, while the proportion of all workers with surgical coverage increased from 36 percent in 1950 to 72 percent in 1965 [7]. Employers essentially assumed the responsibility for subsidizing employees' health care costs. However, not all employers offer health insurance benefits to their employees.<sup>4</sup> In addition, the trend toward employer-based

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4. In 1993, 78 percent of wage and salary workers had access to employer-sponsored health insurance, and 63 percent participated [8]. Coverage and participation rise with size of firm.

coverage and experience rating did not address the issue of coverage for the unemployed and the retired elderly.

## Early federal programs

While the federal government “remained neutral” on comprehensive national health insurance, it did initiate the following legislation aimed at improving the supply of health care services:

- The Hill-Burton Act of 1947 subsidized the construction of hospitals.
- The GI bill supported veterans in their pursuit of a college education and professional training, including medicine.
- The National Institutes of Health and the Health Manpower legislation supported the training of physicians, especially in certain areas of specialization and research [5, 9].

Two pieces of federal legislation focused on improving access to medical services for select segments of the population: the Social Security Act Amendments of 1950 and 1960. Under the Social Security Act of 1935, the federal government established a program of public assistance for people who were unable to work. Those potentially eligible for assistance were the needy, the aged, the blind, single women with children, and later, the disabled. While the Social Security Act did not originally target direct assistance for medical care, it was included in the formula for determining the amounts of support necessary. State participation in the program was optional. Those states participating shared the cost of the program with the federal government [5, 9].

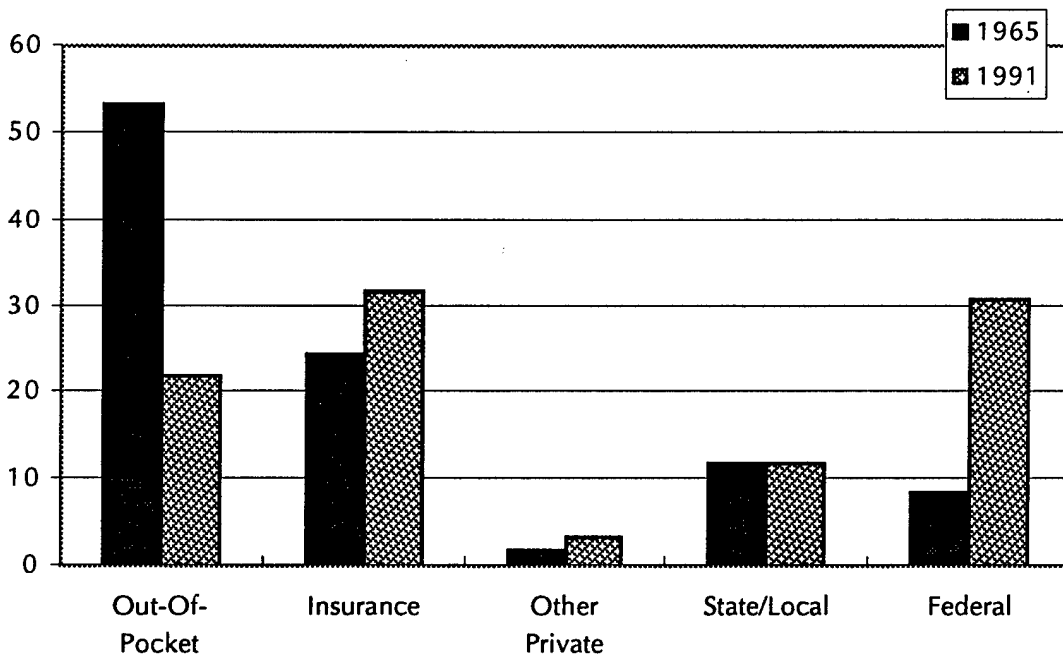
The Social Security Act Amendments of 1950 provided matching federal funds to state public assistance programs for payments to physicians, hospitals, and other health care providers. The Social Security Act Amendments of 1960, also known as the Kerr-Mills Act, made an open-ended commitment to pay for an established set of health care services, increased the federal cost-share, and authorized a new program of medical assistance for the medically needy elderly [5, 9, 10]. State participation in either program was optional. By 1965, all states had established a basic public health care assistance program, and

47 states had added to their programs the optional coverage for the medically needy elderly [10].

## Changing picture of health care

Prior to 1965, most spending on health care came from the private sector. Roughly 80 percent of spending on health care was paid out of pocket or by private insurance companies on behalf of their customers. Figure 1 shows the breakdown of spending in 1965 compared to 1991 [11]. The private spending in 1965 was primarily based on out-of-pocket spending.

Figure 1. Source of payment for medical expenditures, by percent, 1965 compared to 1991<sup>a</sup>



a. Source: [11].

Because private insurance is available primarily as a function of employer-offered policies, older people who were retiring faced the loss of insurance at the same time as their income declined. This



created concern on behalf of the elderly, who could expect to experience the following as they retired:

- Increased health problems that come on with age
- Loss of earned income
- Lack of private health insurance.

In addition, there was concern for the health needs of the poor who had no private insurance.<sup>5</sup>

## Expansion of government programs

In 1965, the Medicare and Medicaid programs were instituted, to provide minimum guarantees of health care for the elderly and poor. Since 1965, responsibility for health care spending has shifted drastically. Now a much higher share of health care spending is absorbed by the government sector, primarily the federal side, and much less is out-of-pocket spending on the private side, as figure 1 shows. In 1965, before the Medicare and Medicaid programs were implemented, the federal government paid directly for 8 percent of health care expenditures. By 1991, the federal government's share was 31 percent, and adding state and local payments added up to 43 percent of expenditures, reflecting a major shift in the players in the health care market.

The out-of-pocket share of costs has dropped from more than 50 percent to about 22 percent of expenditures. However, the share represented by private insurers has risen from 24 percent to 32 percent, which reflects strong growth but does not account for the drop in out-of-pocket payments. This drop is reflected most strongly in the increased share of expenditures absorbed by the federal government, with the Medicare

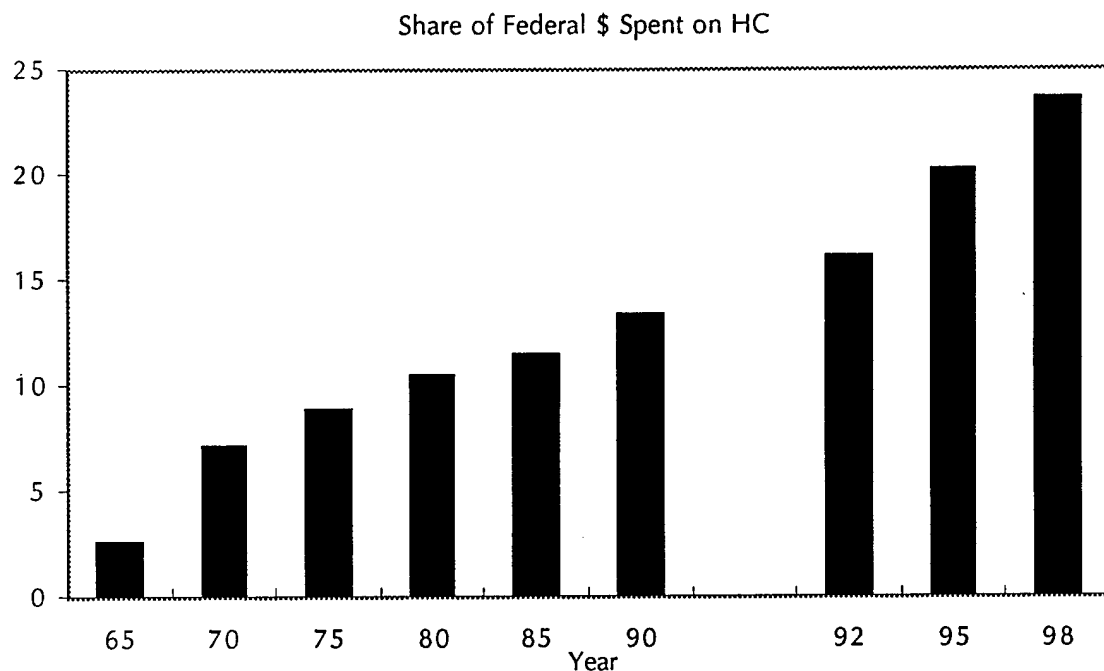
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5. Medicare and Medicaid were established in response to long-running efforts to create national health care reform. When Medicare and Medicaid started up in 1965, there had already been three failed efforts at national health care reform. Medicare and Medicaid grew out of President Truman's inclusion of national health insurance among proposals for the Fair Deal. His proposal was linked to socialism and communism, and was defeated, but the ideas resurfaced with the goal to provide health insurance to the elderly.

and Medicaid programs. The relative share of total health care spending attributed to state and local government has remained constant at 12 percent. Of course, the size of the spending has increased greatly; figure 1 indicates only relative shares, not magnitudes.

Turning to examine magnitude, we see that federal spending on health has grown tremendously over recent decades. In 1965, federal health spending was \$3.1 billion, and accounted for 2.6 percent of federal spending. The addition of Medicare and Medicaid in 1965 added to the burden of federal spending, and, by 1970, health spending was 7.1 percent of federal spending. Figure 2 shows the share of health spending in the federal budget.

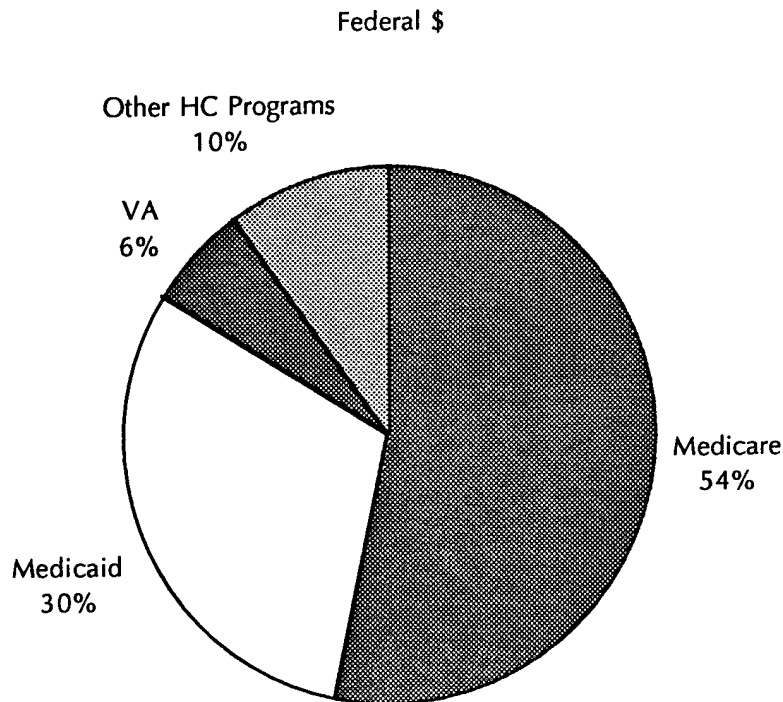
Figure 2. Time line of percent of federal spending on health, 1965–1998 (projected)<sup>a</sup>



a. The entries progress in five-year increments until 1990, where the graph breaks. The entry for 1992 is actual, whereas the 1995 and 1998 entries are Congressional Budget Office (CBO) projections. In addition to Medicare and Medicaid, other federal spending includes federal employee and annuitant health benefits, plus other health services and research. Federal spending on health excludes spending on the military's CHAMPUS program [11].

Figure 3 shows how the direct federal health spending is allocated for 1992. Of the \$222.7 billion devoted directly to health spending, Medicare absorbs the highest share, with Medicaid in second place. Together, they account for 84 percent of federal health spending.

Figure 3. Relative share of total direct federal health spending, by program, 1992<sup>a</sup>



a. Source: [11].

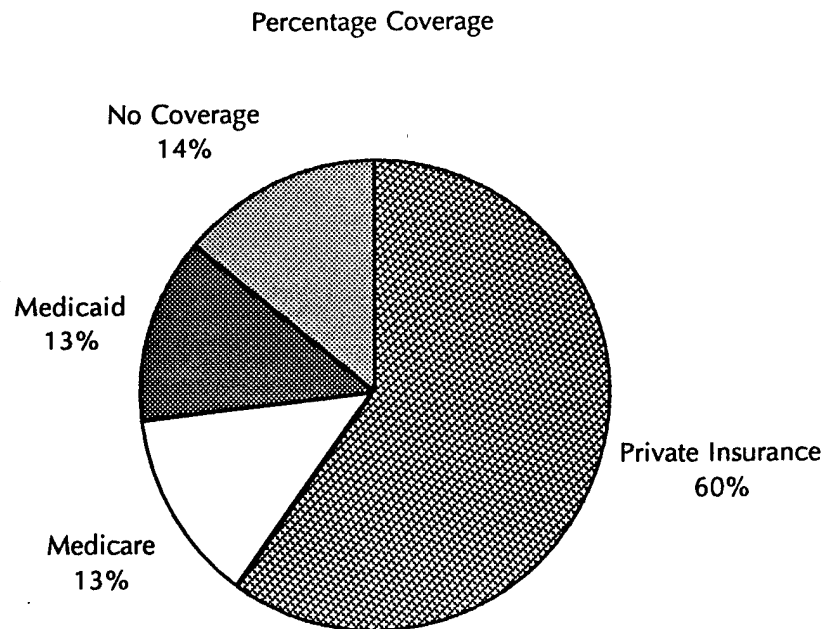
To understand what forces drive our health care system today, we must consider the influence of Medicare and Medicaid. The federal government has become a major player in the health care arena, and Medicare and Medicaid dominate the government's health care expenses. In addition, the growth of spending raises concern about the size and scope of these federal programs. How will the federal government respond to continued spending increases? Do we want to

slow down the growth of Medicare and Medicaid? If so, what measures should we take?

## Health care coverage

To add to the picture of health care spending, figure 4 shows the distribution of health care coverage for our population. Although 60 percent of the population has private insurance, there is still 26 percent covered by the government and 14 percent uninsured.<sup>6</sup>

Figure 4. Distribution of sources of health coverage, 1994



6. See *State Initiatives in Health Care Reform*, Number 11, March/April 1995 (included in [12]). Analysis is based on Census data. A recent study indicates that at least 14 percent of the population, or 17 percent under the age of 65, had no health coverage—private or public—for some or all of 1994 and that this percentage has been rising for at least 6 years [12].

This means that 40 percent of our population already depends primarily on the government as a provider of health care. This dependency derives from formal programs (Medicare, Medicaid, public health-clinics) or through informal methods (show up at the emergency room and rely on charity).<sup>7</sup>

From the private side of the market, we focus in this paper on identifying cost-saving mechanisms used to limit costs and slow the growth of premiums. By looking at how the private market is changing, we can glimpse the probable changes coming along for our federal health care programs. The federal programs do have cost-containment measures in place. However, the growth of spending in the private market has slowed considerably in recent years. Much of this progress has been achieved by giving private consumers incentives to be conscious of costs.

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7. Uninsured people place stress on the system of health care. Those with no insurance coverage may not receive regular health care, but rather may seek care only when a serious condition develops. They may be seen at emergency wards or in hospitals and clinics on a nonreimbursable, or charity, basis. Costs of this type must be covered somehow, usually in one of two ways: cost shifting to those with insurance, and through use of tax revenue to reimburse institutions for nonpaid care.

## Private health insurance

First, we will take a brief look at the nature of the private health insurance market and the interaction of insurance companies, employers, and employees. Then we will focus on the changes that have occurred in recent years, regarding the pressures to reduce health care expenditures and the cost-containment methods that have come into being. Many of the methods, such as copayments, have been used for years but are now being applied in new ways. Finally, we will take a look at the evidence of how the industry is changing and will inquire as to whether the cost-containment methods seem to be working.

### Who pays for private health insurance?

Most private health insurance in the United States is negotiated for by employers on the behalf of qualified employees. For those age 65 and under, 85 percent of private health insurance is purchased by employers for employees [11]. Thus, it is largely an employer-driven system, in the sense that employers are the negotiating units in selecting an insurance carrier or carriers and the range of health benefits that will be offered to employees. Other arrangements exist, but the employer-driven model is the most common way of obtaining health insurance. Variations include:

- Employer-provided insurance, with negotiation by employer and employee union representation
- Employer self-insured coverage
- Individual purchase, mostly by self-employed individuals
- Individual purchase, by employed individuals who are not covered by their employer for various reasons (e.g., no coverage offered, part-time status)

- Individual purchase through a high-risk pool, usually subsidized through a government plan
- Individual purchase as a member of a professional organization that has buying privileges for its members.

In general, employer-driven insurance coverage is cheaper than insurance available through individual purchase, looking at comparable coverage packages. This occurs for several reasons:

- The employer, especially if representing a large number of employees, can often obtain a discount on the premium for coverage.
- Usually the employer pays a substantial share of the premium cost as part of the employee benefit package.
- Individuals buying coverage are viewed with suspicion: Are they high users, or do they have preexistent conditions that make them high-risk?

Of course, the employer who pays a share of the premium as a benefit is unable to offer this money in wage increases. Conversely, to say that a person pays less because the company picks up a substantial share of the cost of coverage is incorrect because the person pays in terms of lost potential wages. However, most people do not view the matter in quite this way. They perceive that the employer is paying the cost, and do not realize or acknowledge that they pay through foregone wages. According to a 1992 CBO report, since 1973, employer payments for employee health insurance premiums "absorbed more than half of workers' real (adjusted for inflation) gains in compensation, even though health insurance represented 5 percent or less of total compensation" [11].

This lack of recognition that employer-provided health insurance is in fact paid for by employees is an important issue. First, there are tax advantages to individuals in taking part of their wages as untaxed employee benefits. This tax advantage is more substantial the higher the income of the individual. Second, the perceived value of a benefit such as health insurance varies for different people. A family coverage for a good health maintenance organization will cost roughly \$4,000 annually. Some plans cost much more than this. If the same benefit is

provided to all full-time employees of a company, it may be perceived as "worth" more to the service staff than to the managers. The service staff will have much lower average salaries, and a \$4,000 benefit will be a large relative benefit to them.

Viewed another way, if the company did not offer health insurance, but increased all employee pay by \$4,000, and the insurance was readily available in the open market for \$4,000, the service staff would be less likely than the managers to purchase the policy. In this sense, employer-driven insurance has a disproportionate effect: the coverage may enable low-paid employees to obtain coverage that, on their own, they would not feel they could afford, given the competing demands for their income. Health insurance is a market in which perceptions and gambling play important roles. If people rate their probability of needing health insurance as low, they are likely to divert scarce funds to another use, especially if they expect to find other sources of assistance if a medical disaster occurs.

However, the company would not want to give each employee an extra \$4,000. The average cost of health insurance of \$4,000 represents the cost of providing coverage to all employees who take coverage. This is based on the benefit structure required to be competitive for the range of employees hired by the firm. It is likely that adding \$4,000 to each employee would bring lower paid workers above their competitive wage, and would fail to adequately compensate highly paid employees who were reaping a significant tax advantage of having the health benefit in untaxed form. In addition, because each employee would now pay taxes on the extra \$4,000 (federal, state, and social security taxes), there would not be enough left to pay for health coverage unless each employee paid the difference out of pocket.

Excluding health insurance from income carries a different value depending on the tax status of the family. Lewin/VHI has estimated that the exclusion is valued at roughly \$600 for a family with income between \$20,000 and \$30,000, whereas for a family with income of \$75,000 to \$100,000 the exclusion is valued at over \$1,400.<sup>8</sup> Feldstein

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8. 1991 estimate using the Health Benefits Simulation Model, Lewin/VHI [11].



estimates that the federal government loses \$45 billion in uncollected taxes and \$27 billion in foregone social security taxes each year due to the tax exclusion on employer-provided private health insurance [11].

Trends with provision of employer-sponsored health insurance include:

- “Paying” for only the individual employee’s premium—employee picks up most, or all, of the cost of extending the policy to family coverage
- Paying only a (decreasing) percentage of individual and/or family coverage<sup>9</sup>
- Telling the employee the amount of the total premium
- Offering a policy with less coverage, higher deductibles and copayments, or some combination of the above
- Limiting choices of employees to select among competing health plans
- Offering only managed choice health plans
- Becoming self-insured
- Deciding to not offer health insurance as a benefit.

## **The private market reaction: cost-containment measures**

The rising cost of health care became a hot issue for business in the 1980s. The recession made businesses concerned with cost-cutting, in part to remain internationally competitive. Health insurance, the fastest growing labor expense, became a target [11]. Firms wanted insurers to curb medical utilization and costs. As a result, employers and insurance companies started working together to hold down the cost of providing health care coverage.

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9. In 1989, 54 percent of employers paid the entire premium for single employees, and 34 percent did so for employees with families. These percentages have fallen compared to earlier periods. From a Bureau of Labor Statistics survey [11].

Efforts to control costs generally rely on methods to:

- Shift more direct costs to consumers
- Divert care to lower cost methods
- Restrict patient choice of services
- Limit intensity of use of services.

Some of the mechanisms used include:

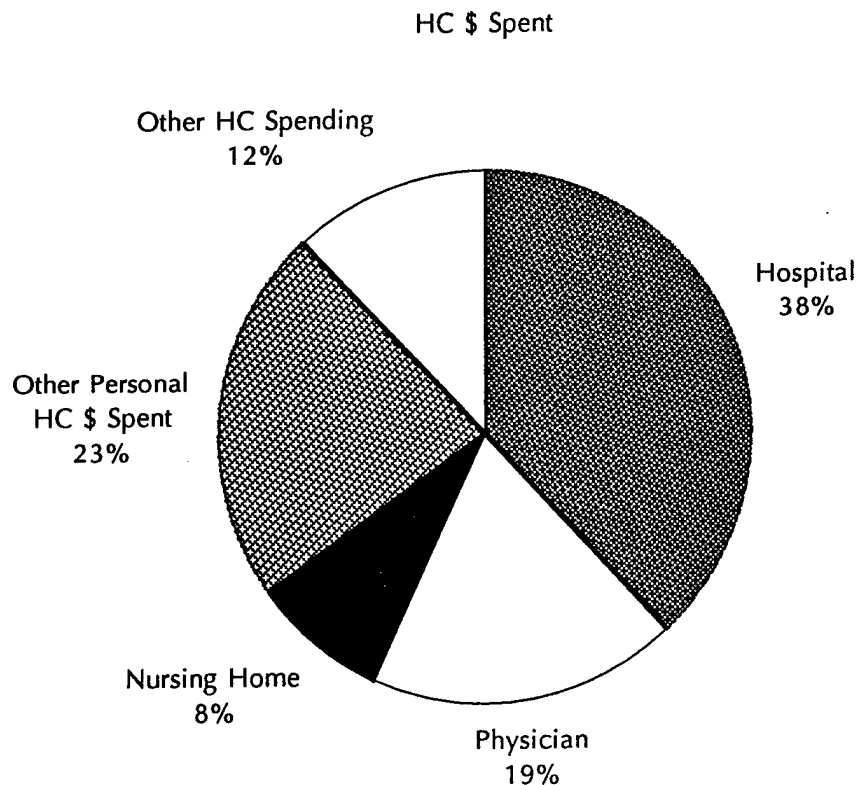
- Substitute outpatient care for inpatient care (ambulatory care, same-day surgery). Insurers may pay full costs of the outpatient care, so beneficiaries willingly switch from the much more expensive inpatient care.
- Make beneficiaries cost-conscious by means of copayment and deductible increases and different rates for different procedures.
- Require preauthorization for hospital admissions, or do not pay for a substantial part of the hospital charges (admission utilization review)
- Conduct utilization review for hospitalized patients, such as review of length of stay (refuse to pay for inordinate lengths of stay without proof of justification).
- Use case management techniques to find lower cost alternatives for care in extremely expensive cases (e.g., home health care or hospice care).
- Require second surgical opinions: before approving surgery, patients must get a second opinion from a source unconnected with the original physician.<sup>10</sup>

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10. This requirement has recently fallen out of favor, as it may have added more to costs than it saved. The additional consult added to costs, and second opinions tended to support the original recommendation, so surgeries were not being avoided [13].

Figure 5 indicates how we spend our health care dollars today. The largest category is hospital expenditures, at 38 percent, followed by personal health care spending (23 percent) and payments to physicians (19 percent) [11]. Nursing home care takes 8 percent of the share. Given the distribution of spending patterns, it is not surprising that many cost-containment methods have focused on hospital spending as the primary way to cut spending. However, other methods of cost-containment are being used as well.

Figure 5. Spending on health care—percentage share by source, 1991



Since the early 1980s, private insurers and the government have sought improved efficiency in health care delivery. Instead of paying

hospitals based on the cost of the services rendered, payments are now based on fixed rates determined by diagnostic related groups (DRGs). Insurance companies have demanded cost efficiencies based on efforts to compete for business contracts and keep premium charges low. Organizations reflecting managed care have gained an increasing market share. The evidence suggests that the private market has made strong efforts to curb the rising cost of health care, at the levels they are able to influence.

In addition, a potentially important legal change occurred in 1982, as the U.S. Supreme Court held that antitrust laws applied to the medical sector. Successful antitrust cases have been brought against:

- The American Medical Association (restrictions against advertising)
- A medical society threatening a boycott against an insurer regarding physician fee increases
- A dental society for a boycott against insurer cost-containment measures
- Medical staffs denying hospital privileges to HMO physicians
- Hospitals trying to merge.

It quickly became apparent that the medical sector was no longer immune to antitrust legal action [11]. However, how much of an impact these legal changes will have on health care costs remains unclear at this time. Some changes, such as relaxing restrictions against advertising, should encourage competition and reduce costs. However, the magnitude of the impact on costs is unknown.

## **Trends in the civilian sector**

The health care delivery system has changed considerably in recent years. We are moving to less fee-for-service health care and more managed care. Managed care encompasses many variations, from preferred provider networks to health maintenance organizations. However, the key is a movement away from beneficiaries being able to select care, at whatever cost, and have the insurer pay for the

treatment (or receive reimbursement). There are several cost-control mechanisms that try to contain our growth in health care spending, affecting inpatient and outpatient care as well as alternative choices of treatment.

## **Specific cost-containment methods and mechanisms**

There is a great deal of variety in how health care insurance is sold and health care services are delivered. The basic method for health care insurance in the 1970s was indemnity insurance, also called fee-for-service (FFS). In a typical FFS plan, beneficiaries chose their own physicians and contracted for their own selected level of care. Provider fees were either paid directly by the insurance company or paid by the patient, who was then reimbursed. Often the beneficiary shared in costs through paying a deductible and modest copayments.

Over time, this simple FFS model has changed and taken on many forms. In this section, we discuss some of the old cost-containment methods and mechanisms, such as deductibles and copayments, and the changes that have occurred. In addition, we explore a variety of new cost-containment procedures that have developed and have been modified in recent years.

### **Deductibles**

Deductibles are dollar amounts that represent trigger points. Once a person has medical costs—of an allowable type and of an amount considered to be usual, customary, and reasonable (UCR)<sup>11</sup>—that exceed the deductible amount, private insurance will begin to help pay for subsequent medical costs. The deductible implicitly requires

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11. The definition of UCR is usually determined as follows. "Usual" is the fee most frequently charged by a provider for the particular service or supply. "Customary" implies that the charge is within the range of fees usually charged for the particular service or supply by providers of similar training and experience in the same locality. "Reasonable" applies to a charge when it is "usual" and "customary," or the carrier judges the charge to be justified because of unusual circumstances (e.g., the complexity of a surgical procedure) [13].

individuals to pay for ordinary, low-level routine costs, which discourages overutilization of this type of care.

Often the insurance company requests that individuals “save” their claims until they have enough to exceed the deductible. This saves on processing costs because:

- Some people never exceed the deductible (no claims are filed).
- Fewer total claims must be processed.

Recent trends have been for the deductible to rise—in some cases, doubling. This is partly due to rising medical costs; deductibles can be expected to rise as costs increase. However, it also reflects an effort to hold down costs and limit claims. If a larger deductible limits claims to be processed and paid, and limits the number who even file claims, reimbursement costs will fall. This helps dampen the rising trend of premium costs for the basic insurance package.

### **Copayments**

Copayments discourage overutilization of services once a deductible has been met. The beneficiary shares the payment for services based on a percentage of the UCR costs. If the cost is for a nonallowed service (e.g., cosmetic surgery), the beneficiary pays the full charge. If the cost is above the UCR level, the beneficiary covers the stated percentage copay of the UCR cost, plus the amount above the UCR level.<sup>12</sup> This structure discourages inappropriate or unnecessary care. The trend in this area is simple: increase the copayment shares. The basic copayment share is usually 20, 25, or 30 percent, although for some types of care the copay may be as high as 50 percent.<sup>13</sup>

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12. Insurers may bargain for agreements with some providers to reduce their charges to the UCR level.

13. For example, for the federal Blue Cross Blue Shield high coverage, the copayment is 80 percent for general medical treatment; for standard coverage, the copayment is 75 percent. For mental health coverage, the high option has a 30-percent copay, whereas the standard option has a 40-percent copay [13].

Copays also steer beneficiaries in certain directions. Those who use physicians or laboratories from a list of preferred providers may receive care with a lower copayment. Using a preferred hospital may mean that no copayment for hospital care is required, except for non-allowed treatment or care above the UCR level.

### **Catastrophic maximum**

Catastrophic maximum is an amount, considerably higher than the deductible, that represents an unusual amount of medical expenditures. After this amount of cost has been absorbed by the family or individual, the insurer absorbs the copayment. Care that is not allowable or above the UCR amount will still be the responsibility of the beneficiary, which keeps some controls on the amount of spending that will be reimbursed.

The trend is for the amount of the catastrophic maximum to move upward over time, and for different levels to be set for different kinds of treatment. For example, there may be different levels of the catastrophic maximum set for medical vice mental health care.

### **Lifetime/annual maximum**

The lifetime or annual maximum reflects an upper bound on total reimbursement for an individual or family. An annual maximum limits the amount an insurer must pay for a given policy year, whereas the lifetime maximum is calculated over the life of the policy.

Annual and lifetime maximums are often set separately for medical care expenses, mental health care expenses, and substance abuse and/or rehabilitation expenses. In general, few people expect to exceed a maximum amount. However, the amounts can be set so low that a condition requiring extensive care quickly exhausts the coverage, leaving the individual to absorb subsequent costs.

### **Preferred providers**

The insurer may give a list of preferred (low cost) providers to beneficiaries. Usually, the insurer offers added levels of reimbursement if the beneficiary uses a preferred vice nonpreferred provider. The insurer may negotiate reduced charges from preferred providers in exchange for directing beneficiaries in their direction. Sometimes

reduced charges are not necessary; the preferred providers are simply charging at rates acceptable to the insurer, and are thus included in preferred status.

Beneficiaries who do not use preferred providers may pay a higher share of the fees charged by nonpreferred providers. This causes some difficulties:

- People do not like to switch from providers they have used in the past, and who may not be on the preferred list.
- Providers on the preferred list may not have openings for many new patients.
- There may be a long wait for appointments among the preferred providers.

Generally speaking, a large insurer will have a large list of preferred providers. However, smaller insurers have problems offering a comprehensive list covering all specialties and geographic areas.

#### **Gatekeepers/primary care managers**

Other arrangements to limit beneficiary access to expensive specialty care rely on managing initial diagnoses and recommendations for follow-up care. Each beneficiary, or family, may be assigned (or allowed to choose) a primary care physician who screens for appropriate care. The beneficiary must first seek an evaluation or care from a gatekeeper/medical manager, who decides what care is appropriate. Unless the manager believes it is appropriate to consult a specialist, care will be given by a primary care physician, limiting the use of costly specialists. If a person feels the need to consult a specialist without the approval of the primary care manager, he or she will usually have to pay a large share of the cost or, in many cases, pay for the entire cost of the unapproved care.<sup>14</sup>

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14. Such cases have some mechanisms for dispute resolution. If the person can document a medical need for specialty care, beyond what was available from the primary care level, the insurer may be required to accept responsibility for the charges.



## **Additional methods used by managed care—HMO plans to attain efficiencies**

The typical Health Maintenance Organization (HMO) offers pre-paid centralized provision of health care.<sup>15</sup> The beneficiary pays an annual premium but then faces very low costs for health care afterward, so long as care is obtained through the HMO. There are usually no deductibles, and copayments are quite modest. The HMO offers a range of care and often pays for preventive care, such as physical examinations and immunizations, which are often excluded from FFS plans. The beneficiary is usually attached to a primary care physician, who screens patients and determines whether follow-on care with a specialist is required.

In general, all health care received must be either at the HMO or arranged with the assistance of an HMO primary care physician. The HMO usually will provide care only in facilities it owns or contracts for, using member physicians, hospitals, and clinics. If beneficiaries want to receive care outside this setting, they must arrange for the care privately and pay for it separately, and they will rarely be reimbursed.

In addition to restricted access to specialists and facilities, managed care plans use utilization review, cost sharing, and capitation methods to pay physicians to contain costs—partly to retain profits, and partly to keep premiums low to be able to compete for customers (beneficiaries). Capitation methods to pay physicians are primarily an HMO technique. It is often combined with profit-sharing or bonus arrangements for physicians.

If enrollee costs are held below the annual capitation budget, physicians are rewarded by a share of the extra profit—a positive incentive for physicians to contain costs. On the negative side, physicians may be evaluated on the basis of average number of patients seen per day and average number of minutes spent per patient. Physicians who are above average with respect to these metrics may be reprimanded or, in the extreme case, may not have their contracts renewed.

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15. There are many variations of HMOs, with new arrangements appearing each year.

## Changes in insurance?

The shifts taking place in the private insurance market reflect the rapidly changing patterns of health care provision in the United States. The 1980s demonstrated the culmination of various alterations made in the private insurance market. As of 1981, as shown in figure 6, only 5 percent of the nation's private insurance market could be described as represented by HMOs, while 95 percent would be described as being traditional (fee-for-service) insurance.

By 1990, as shown in figure 7, the picture of private insurance had changed drastically. Fully 20 percent of the insurance market was represented by HMOs, with an additional 5 percent described as HMO-plus, or point-of-service (POS). POS is an HMO with an opt-out option of outside coverage at a very high copay, typically of 50 percent. Only 5 percent of the market remained as traditional insurance. The remainder had shifted to variations of managed care, with the largest share (57 percent) represented by traditional insurance (FFS) with utilization review procedures. Another 13 percent had gone the route of the preferred provider organization (PPO).<sup>16</sup>

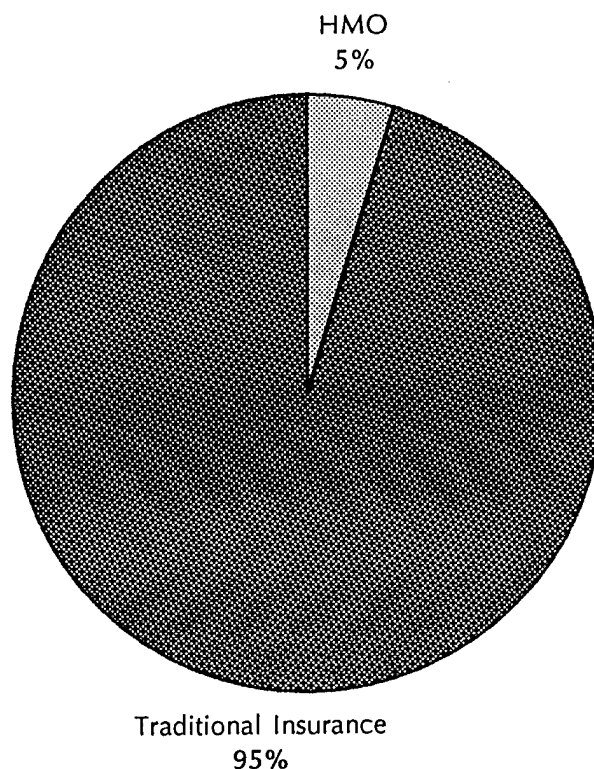
## Evidence on changes in utilization

Hospitalization accounts for a large share of health care expenditures, so many efforts to establish the effectiveness of cost-containment measures focus on inpatient care. Based on evidence from Blue Cross, admissions per 1,000 beneficiaries dropped by 29 percent from 1970 to 1990, along with declining length of stays [11]. Another study indicates that hospital admissions dropped by 22 percent in the decade from 1980 to 1990, whereas patient days fell by 24 percent [11]. In addition, hospital occupancy rates declined from 76 percent in 1980 to 66 percent in 1993, generating additional excess capacity [11]. We do not have very good evidence as yet for what is happening to costs for outpatient care.

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16. With the many changes taking place in insurance plans, new variants are created each year. There are now many hybrid plans that would overlap these categories or require new definitions.

Figure 6. Distribution of private insurance held, 1981<sup>a</sup>



a. Source: [11].

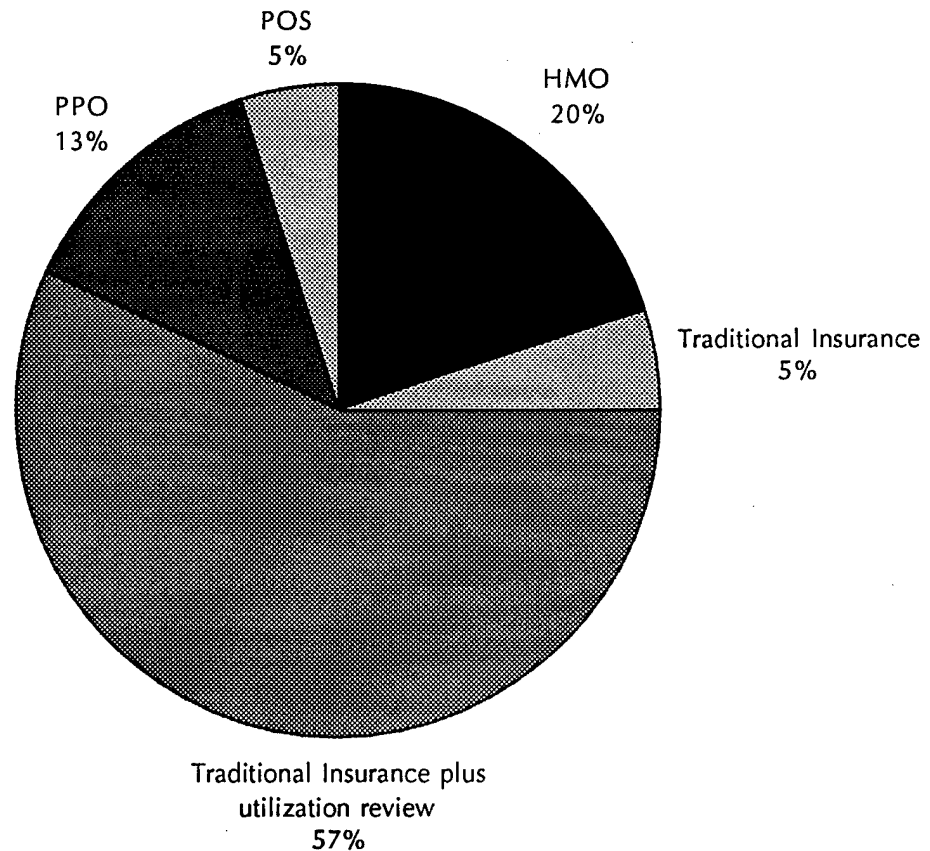
*Traditional health insurance:* Patients are permitted to go to any provider; the provider is paid on a fee-for-service basis. The patient normally pays a small deductible plus 20 percent of the provider's charge, up to an annual out-of-pocket limit of \$3,000.

*Health maintenance organization (HMO):* An organization providing comprehensive health care services to a voluntarily enrolled membership for a prepaid fee. An HMO controls costs through stringent utilization management, payment incentives to its physicians, and restricted access to its providers.

However, information is available on the premium charges for private insurance, which reflect overall costs. A recent study looked at premium growth rates for 95 insured groups from 1985 to 1992 [14]. The evidence showed that, for single-employee premiums, the growth rate increased from 1986 through 1989 quite sharply, and then began to fall substantially through 1992 (although the growth rate is still positive in real terms). It is possible that this reflects the effects of cost-containment methods being implemented during the decade of the 1980s.

The authors indicate that significant factors influencing premium growth rates include deductible levels and coinsurance rates.

Figure 7. Distribution of private insurance held, 1990<sup>a</sup>



a. Source: [11].

*Traditional health insurance with utilization review (UR):* Fee-for-service payment to providers, annual deductible and copayment by patients, plus utilization review, which consists of review of hospital utilization to evaluate the appropriateness, necessity, and quality of care provided. Preadmission certification, concurrent review, and retrospective review are part of the UR process.

*Preferred provider organization (PPO):* A third party payer contracts with a group of medical providers that agrees to furnish services at negotiated fees in return for prompt payment and a guaranteed patient volume. PPOs control costs by keeping fees down and curbing excessive service through utilization management.

*Point-of-service (POS):* An HMO that permits its enrollees access to nonparticipating providers if the enrollees are willing to pay a high copayment each time they use such providers.

## Summary of private insurance trends

Although changes are still occurring, it is clear that the basic nature of private insurance has responded to attempt to deal with the issue of rising costs. Various methods of cost containment have been instituted, and new methods are still emerging. From the private side of the market, there has been considerable success at changing the nature of the insurance process, with beneficiaries having a better understanding of the costs and issues, and a slowing of the rapidly rising costs for health care. However, we do not have a complete picture of the effectiveness of the cost-containment measures as yet (e.g., outpatient costs), and the market is still evolving.

## Public health insurance: Medicare and Medicaid

With the creation of Medicare and Medicaid in 1965, the federal government acquired a new role in the health care industry as a major purchaser of services. Since 1970, the distribution of national personal health care expenditures has shifted to favor third party and government payers, particularly the federal government. In 1990, the proportion of direct patient payments had declined to 23 percent, while private third party and federal government expenditures had increased, respectively, to 36 and 30 percent. In 1992, third party payers and the federal government each were responsible for 33 percent of national personal health care expenditures.

Economic and political forces are working to change the Medicare and Medicaid systems. Perhaps the largest single driving force for change is the rapid growth in these programs. In recent years, the growth of Medicare and Medicaid expenditures has exceeded that of the private sector. Figure 8 shows the annual growth rate of nominal Medicare, Medicaid, and private health expenditures since 1990. Although all three sources of health expenditures began the nineties with relatively high growth rates—around 11 percent—by 1994 the private sector's growth rate was less than half the growth rate of Medicare and Medicaid.<sup>17</sup>

In 1991, Medicaid expenditures increased by about 22 percent, reflecting coverage and eligibility mandates of the 1980s and states' increased use of special federal financing mechanisms.<sup>18</sup> By the year 2000, the Health Care Financing Administration (HCFA) estimates

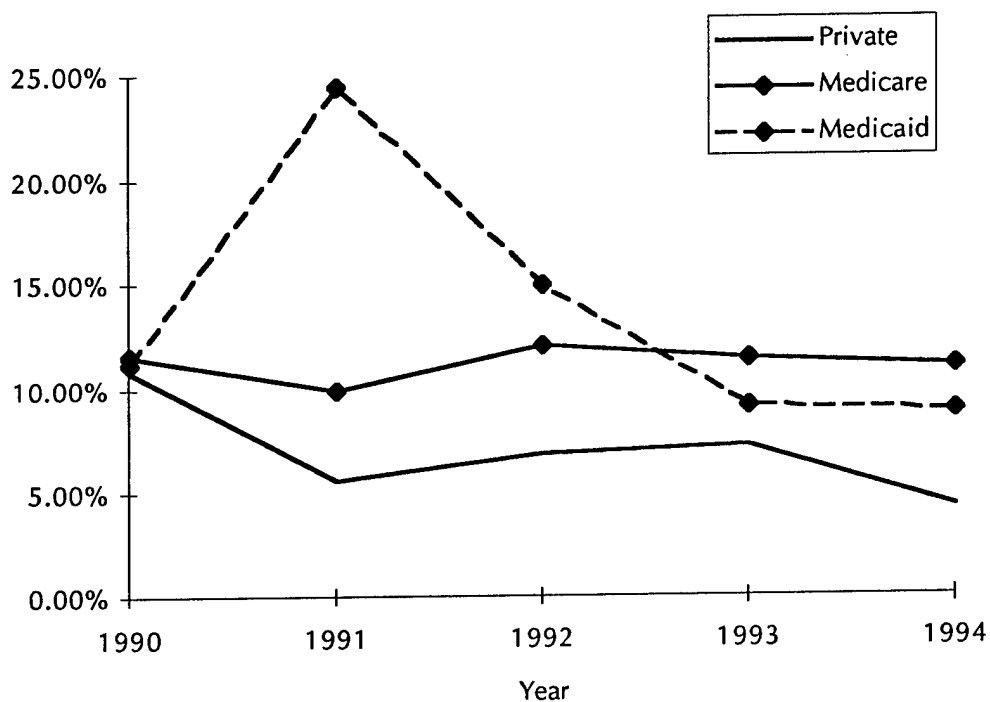
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17. Note that the general CPI ranged from 5.4 to 2.6 percent over these years.

18. These issues will be discussed in further detail in the section on Medicaid.

that Medicare will spend \$293.5 billion, up from \$171 billion spent in 1994 [1].<sup>19</sup> This assumes an annual increase of roughly 9.5 percent. The Congressional Budget Office estimates that federal Medicaid expenditures will increase to nearly \$150 billion by FY 2000, up from about \$75 billion in fiscal 1993 [15].

Figure 8. The growth of national health expenditures<sup>a</sup>



a. Source: [16], nominal data.

## History of the programs

Medicare and Medicaid have undergone a number of changes through several distinct legislative periods. From 1966 through 1975, Medicare and Medicaid experienced both eligibility expansion and

19. Cost estimates are not adjusted for inflation.

regulatory reform, followed by a period of legislative inaction in the mid- to-late 1970s. During the latter period, national attention was focused on the country's economic problems, and with respect to health care policy, on the issues of national health insurance and continuing inflation in hospital costs.

The Reagan years marked a period of legislation targeted at achieving cost containment via competition and deregulation. The Bush administration advanced a broad, market-based reform that would minimize the role of the government. Bush's plan included such items as the use of tax credits for purchasing private health insurance, regulation of private insurers' ability to select whom to insure, and reform of the medical liability system [17].

By the end of the 1980s, federal involvement in regulating health care had deepened in terms of the initiatives and reforms authorized by Congress in Medicare and Medicaid. Congress used these programs as legislative vehicles for change. Various reforms were tested in the Medicare and Medicaid programs dealing not only with costs but also the issues of access to and quality of care. Between both programs, six themes predominate these reforms:

- Eligibility-related changes
- Changes in benefits
- Changes affecting provider reimbursement
- Changes affecting program administration
- Changes affecting federal financial participation
- Demonstration authority.

The reforms in these areas represent significant departures from prior law. They have had (and can be expected to have) a major impact on how each program functions for beneficiaries, providers, and, in the case of Medicaid, for the states.

Medicare and Medicaid are programs that have become an integral part of the U.S. health care system. On one hand, changes to these programs have been the government's response to larger social and



economic pressures. On the other hand, with the government as a major purchaser of health care, changes in Medicare and Medicaid have had ripple effects on the entire health care industry and have been important forces in its transition to managed care. In the next two sections, we identify the major changes in these programs during the past 30 years and examine their impact on the overall evolution of the U.S. health care industry.

## Medicare

As we have noted in the previous sections, in an employer-driven private insurance market, the elderly are at a serious disadvantage in obtaining coverage. Congress established the Medicare program to meet the health care coverage needs of our nation's elderly. The program guarantees coverage of hospital costs and includes the option for beneficiaries to purchase for a nominal fee additional coverage of physician services.

Politically, Medicare is a very popular program. It enjoys support not only among our nation's elderly but among the general population. Currently, there are about 36 million Americans who rely directly on Medicare for health care coverage. Even more people rely indirectly on Medicare because it assists many families to provide care for their elderly and disabled family members. Medicare also draws support from those who are approaching eligibility and expect to use it in the not too distant future.

However, maintaining the fiscal solvency of the program has posed a serious challenge. First, age is the best predictor of health care expenditures: as people age, their average health care expenditures rise at an increasing rate. As of 1994, the elderly made up only 12 percent of the U.S. population; however, they account for 36 percent of our national health care expenditures [18]. Second, the age distribution of our population continues to shift: Americans are getting older and living longer. Consequently, the elderly make up a larger share of our population. Medicare also has been affected by inflation in the economy and in medical care prices, expanding technology, and higher utilization levels among beneficiaries [4, 6]. These forces combined have contributed to steady growth in Medicare expenditures. Medicare is

consuming an increasing proportion of our federal budget each year. Projections indicate that, unless the growth rate of Medicare is slowed, the program will consume slightly more than 14 percent of the federal budget by 2000 [19].

In the discussion that follows, we outline the major changes in the Medicare program and explore the impact of those changes on the health care industry. Maintaining the program's solvency while expanding coverage levels to meet beneficiaries' long-term care needs represents the major issue for the Medicare program. Congress has relied on three strategies aimed at cost containment:

- Changes affecting beneficiary costs
- Changes affecting provider reimbursement
- State demonstration authority to develop HMOs.

In terms of containing Medicare costs and maintaining the program's solvency, the results of these changes have been mixed and at best short-lived.

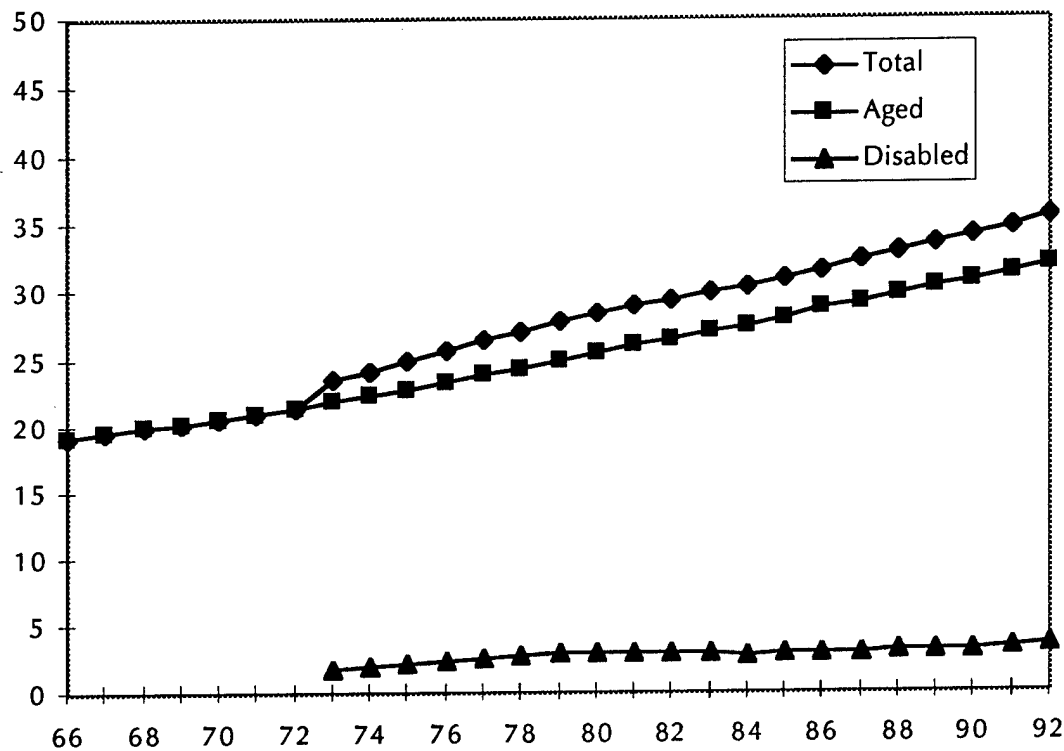
We begin our analysis of Medicare with a brief overview of the program. Next, we examine the key trends in the Medicare program over the past 30 years, particularly in terms of program expansions and costs. What were the major reform efforts? What impact did they have? We then assess the current reform debate and the impact it may have on the health care industry in general.

## **Overview of the Medicare program**

Since 1965, Medicare has provided health insurance coverage to the elderly and, since 1973, to the disabled. The number of Medicare enrollees has grown steadily over time at an average annual rate of 2.2 percent (see figure 9). Elderly enrollees have composed about 90 percent of the total Medicare eligible population since 1973. The remaining 10 percent are disabled enrollees. As of 1992, Medicare provided health care coverage for over 32 million seniors and approximately 3.6 million disabled individuals [20]. Because eligibility is primarily tied to age, Medicare population projections tend to be more

reliable, especially compared to the Medicaid program whose eligible population varies by state.

Figure 9. Number of enrollees (in millions) in the Medicare programs, 1 July 1966–1992<sup>a</sup>



a. Taken from [1].

Medicare benefits include payment for hospital, physician, and other acute care services. Medicare coverage comprises two parts: part A covers hospital, nursing home, and home health care services;<sup>20</sup> part B covers physicians' services, outpatient hospital services, and other

20. Medicare, part A, is also called Hospital Insurance (HI).

ambulatory care.<sup>21</sup> (For a detailed listing of Medicare-covered services, see appendix A). Although most of us think of senior citizens as the primary recipients of this government entitlement, Medicare also covers other individuals. Part A enrollees include:

- Individuals over age 65 who are entitled to monthly Social Security or railroad retirement benefits
- Persons who are permanently and totally disabled for 2 years or more
- People with end-stage renal disease who require renal dialysis or kidney transplants.

The federal government finances Medicare, part A, via a payroll tax on employers and employees. Senior citizens who are not Medicare eligible also may voluntarily enroll in Medicare, part A, at the actuarial cost (currently about \$3,000 per year). In appendix A, we provide a list of the services covered under Medicare, part A, in 1992.

Part B is a supplemental insurance available to all Medicare, part A, beneficiaries. Enrollment is voluntary and requires beneficiaries to pay a monthly premium that covers about 25 percent of the cost of part B Medicare. The remaining 75 percent is financed from general revenues. Most people eligible for part A enroll in part B. In 1990, about 95 percent of the Medicare population enrolled in part B coverage [21]. Part B covers inpatient physician services, home health care (if the enrollee is not covered by part A), outpatient care, and independent laboratories.

In appendix A, we also list those services covered by part B insurance. In addition, we provide a list of those services not covered under either part of the Medicare program. Prescription drugs—a major area not covered by Medicare—represent a large cost to the average senior, and are (partially) covered only if the individual pays for a *private* Medigap policy. Prescriptions form a larger percentage of medical costs for the elderly than for any other age group. The elderly

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21. Medicare, part B, is also called Supplemental Medical Insurance (SMI).

accounted for one-third of the spending on retail prescription drugs, or about \$24 billion, in 1992 [11].<sup>22</sup>

## Beneficiary costs

Medicare beneficiaries face many of the cost-containment mechanisms faced by private insurance beneficiaries. They share in the cost of part B premiums, and have prepaid a share of premiums for part A insofar as they have helped to support previous Medicare recipients based on their payroll tax deductions. In addition, Medicare beneficiaries share a portion of the insurance costs through deductibles and copayments, which are designed to discourage overutilization and recover costs for the government.

In regard to copayments, Medicare beneficiaries face a schedule of payments similar to the private concept of usual, customary, and reasonable. Hospitals must accept assignment; they may not charge a patient more than the amount approved by Medicare. However, physicians may choose not to accept assignment, which means that they can charge beneficiaries directly for the amount above what Medicare will accept as an allowable charge. For example, suppose the physician charges \$500 for an episode of care. Medicare may say that only \$300 is allowable, and will pay 80 percent, or \$240. The beneficiary must pay \$60 as a copayment (unless Medigap insurance will pick up the copayment) and is responsible for the \$200 disallowed by Medicare.<sup>23</sup>

Part A pays for the first 90 days of inpatient hospital care during a benefit period.<sup>24</sup> The enrollee pays a deductible—equal to \$716 in 1995—for the first 60 days with no additional costs. For the 61st through the 90th day, the enrollee pays a copay—equal to one-fourth

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22. This came to about \$750 per person for the elderly in 1992.

23. According to [18], health care spending by the elderly is shared as follows. Medicare pays 45 percent, private sources pay 37 percent, Medicaid pays 12 percent, and other public sources pay 6 percent (based on 1987 data).

24. A benefit period begins with an enrollee's first day of inpatient care. It ends when the enrollee has not been an inpatient in a hospital or SNF for at least 60 continuous days.

of the inpatient hospital deductible, \$179 a day in 1995.<sup>25</sup> Part A also pays for up to 100 days in a skilled nursing facility (SNF).<sup>26</sup>

Medicare has no copayments or deductibles for home health visits by a participating home health agency.<sup>27</sup> Medicare's hospice benefit also has no deductible. Hospice patients pay copays on two items: outpatient prescription drugs and inpatient respite care.

In 1995, Medicare beneficiaries paid a monthly premium of \$46.10 for part B coverage. The annual deductible for Medicare, part B, was \$100. After meeting the deductible, the beneficiary must pay 20 percent of the Medicare Fee Schedule (MFS). In addition, if the beneficiary receives care from a nonparticipating physician, he or she may also have to pay the amount that exceeds the MFS. The Omnibus Budget Reconciliation Act (OBRA) of 1989 imposed a cap on balance billing by nonparticipating physicians. In 1992, a physician could charge no more than 120 percent of the amount listed in the MFS for nonparticipating physicians.

In figure 10, we show the average total beneficiary cost-sharing liability from 1977 to 1992. Average total beneficiary cost-sharing liability per Medicare enrollee has increased from \$174 in 1977 to \$626 in 1991. The average HI cost-sharing liability increased from \$42 in 1977 to \$197 in 1991. Average SMI cost-sharing liability likewise increased from \$132 in 1977 to \$453 in 1991. In 1992, however, the average total cost-sharing liability decreased by approximately 2.6 percent to \$610. The average HI cost-sharing liability rose slightly to \$202, and SMI

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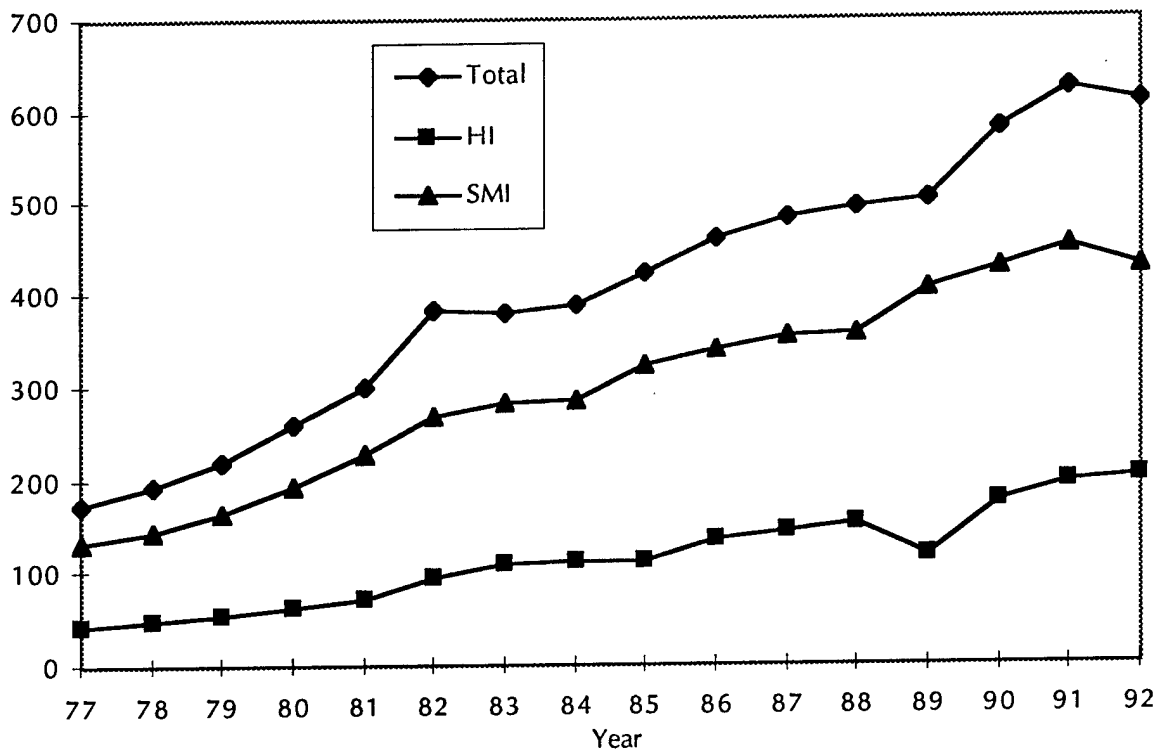
25. If enrollees stay in the hospital longer than 90 days, they may tap their "lifetime reserves." A lifetime reserve is 60 additional hospital days of coverage that may be used. In 1995, the copay for lifetime reserve hospital days was \$358, the equivalent to one-half of the inpatient deductible [22].

26. Patients pay no copays for the first 20 days of care. In 1995, the copays were \$89.50 a day for the remaining 80 days.

27. A home health agency specializes in giving skilled nursing services and other therapeutic services in the beneficiary's home. However, Medicare does not cover general household services, such as laundry, meal preparation, or shopping.

liability actually decreased by 5 percent to \$430. The decrease in the average SMI cost-sharing liability is directly linked to the decrease in SMI balance-billing implemented in 1992 in accordance with the balance-billing cap of OBRA 1989.

Figure 10. Medicare beneficiary cost-sharing liability (dollars per enrollee) by type of coverage: calendar years 1977–1992<sup>a</sup>



a. Taken from [1].

The monthly premium for Medicare, part B, coverage traditionally has covered about 25 percent of part B costs. The monthly premium is essentially a flat rate applied to all Medicare enrollees regardless of other

factors such as personal income. Under the Medicare Catastrophic Coverage Act (MCCA) of 1988, Congress authorized a departure from the traditional method for setting part B premium levels to pay for the increased level of benefits included in the Act.<sup>28</sup> The Act authorized an increase in the part B premiums that affected all enrollees and imposed a surcharge on the income tax of the high-income elderly. High-income elderly beneficiaries led the aged in a storm of protest against the Act. Congress repealed the Medicare provisions of the MCCA in December 1989 before the new benefits were implemented [23].

## **Provider payments**

Medicare and private insurers shared a similar method of payment at the time Medicare was instituted. Beneficiaries sought treatment, and subsequently providers billed the government and the insurer. This method was termed retrospective payment. Both private insurers and the federal government have backed away from retrospective payment over time because it is viewed as failing to contain costs.

### **Hospital reimbursement**

When Medicare was founded, hospitals were reimbursed retrospectively. During the early years of the Medicare program, the focus of the program was on providing the elderly and disabled with access to quality care. There was little emphasis on cost containment. Retrospective reimbursement was an incentive for hospitals to increase utilization because a hospital could increase its revenues by doing so.

Total Medicare program payments experienced an average annual increase of 14.3 percent from 1967 through 1992 (see figure 11).<sup>29</sup>

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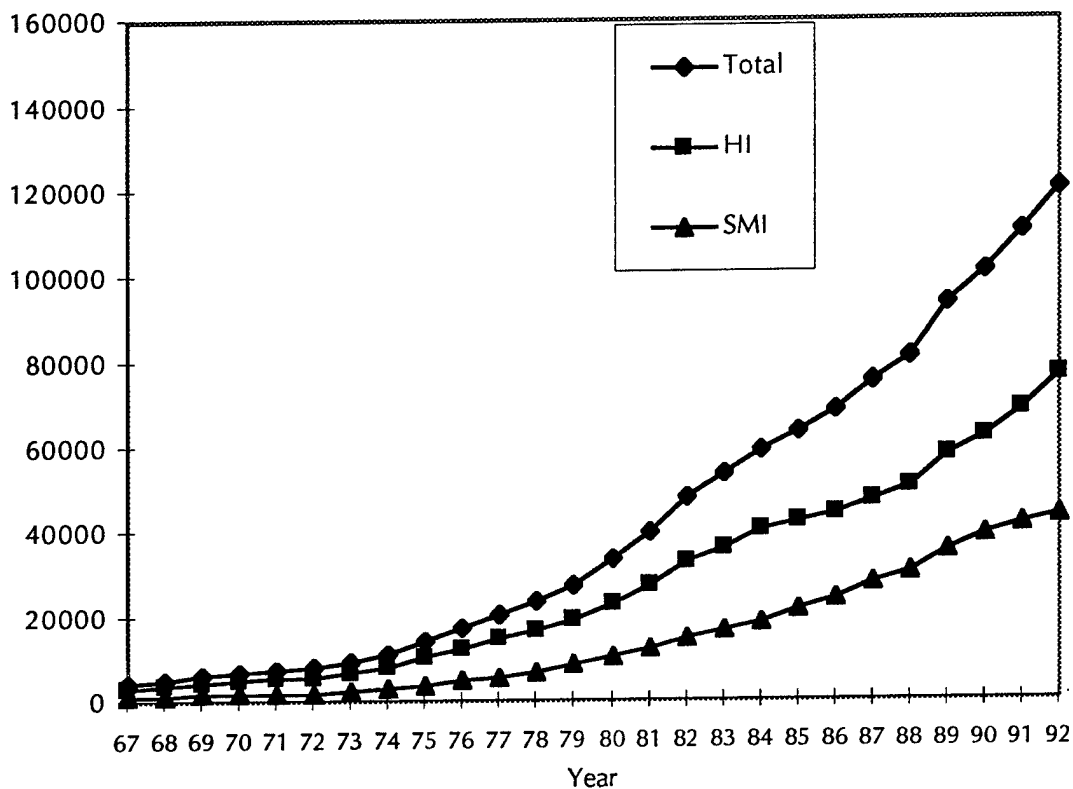
28. In brief, the MCCA extended Medicare coverage to include prescription drugs, nursing home care, and home health services. It also limited beneficiary cost-sharing liability for Medicaid covered services and inpatient hospital benefits (known as the catastrophic cap) [17].

29. We note that program payments reflect the amounts paid in a calendar year and are not adjusted for claims paid after data were compiled. Program payments differ from benefit payments, which include both interim reimbursements and retroactive adjustments made to institutional providers.



Hospital insurance (HI) payments consistently have made up the largest amount of total Medicare costs. Consequently, even though both HI and supplementary medical insurance (SMI) payment levels experienced about the same rate of increase (17 percent) between 1967 and 1983, Congress targeted hospitals initially with cost reforms.

Figure 11. Medicare program payments (in millions), by type of coverage: calendar years 1967–1992<sup>a</sup>



a. Taken from [1].

In response to the upward spiral of Medicare costs, Congress enacted legislation under the Social Security Amendments of 1983, which changed the way Medicare paid hospitals for inpatient care. This

legislation replaced cost-based reimbursement with the Prospective Payment System (PPS). Under PPS, Medicare reimburses hospitals for inpatient health care on a per-case basis. The PPS is based on Diagnosis Related Group (DRG). The DRG system establishes categories of patients who are clinically similar and use similar resources. Medicare reimburses hospitals the same amount for all patients in a DRG category. If the actual costs of a patient are below Medicare's payment, the hospital makes a profit, but if costs exceed Medicare's payment, the hospital takes a loss. From 1983 to 1992, the average annual rate of increase in Medicare hospital expenses had declined to 9.5 percent [1].

### **Physician reimbursement**

Medicare was initially set up to reimburse physicians under a "customary, prevailing and reasonable" (CPR) charge system. The physician was reimbursed the lowest of the following [24]:

- The physician's actual charge for the service
- The physician's customary charge for the service (the physician's 50th percentile charge level for the specific type of service)
- The prevailing charge for the service in the physician's geographical location (the 75th percentile of the customary charges for the service charged by physicians in the physician's area).

Therefore, physicians' reimbursement levels were either dependent on their own charges (i.e., actual charges and customary charges) or the charges of physicians in their geographic locations (i.e., prevailing charges). Medicare limited the growth of the prevailing charges through the Medicare Economic Index (MEI). The MEI is a weighted average of general earnings levels, expenses incurred by physicians, and general inflation. Prevailing charges could increase no faster than the MEI.

The CPR charge system had several inherent problems. First, Medicare did not frequently update the physicians' fee profiles. This meant that new physicians could establish a higher fee profile than older physicians in the same specialty. Second, there were huge

variations in fees in different regions of the country that were not due to cost-of-living differences. Third, Medicare reimbursed specialists at a higher level than nonspecialists for the same procedure [25].

Double-digit inflation persistently occurred under the supplementary medical insurance program. The average annual rate of increase equaled 21 percent from 1974 to 1983 [20]. In response, Congress froze physician fees and began a new series of reforms. Under the Deficit Reduction Act (DEFRA) of 1984, Congress froze physician fees under Medicare for a 15-month period beginning on 1 July 1984 [26]. DEFRA also established the concept of participating physicians. A participating physician is a physician who agrees to accept the Medicare assigned amount on services as payment in full. All physicians were subject to the freeze. However, those physicians who voluntarily participated (accepted assignment) were allowed to bill higher amounts for their services. While the higher charges would not increase their payments, Medicare would use these charges in the calculation of future customary fee updates. Physicians who did not participate could not charge higher fees during the freeze period. By 1986, 27 percent of the physicians signing billing agreements with Medicare accepted assignment.

Congress enacted a number of amendments to DEFRA that extended the freeze on physician fees.<sup>30</sup> In 1986, under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Congress lifted the freeze on fees for those physicians who agreed to participate. For nonparticipating physicians, COBRA authorized a sliding adjustment that used the prevailing charge limits applied to participating physicians during the preceding participation period [26].

In 1989, Congress passed the Omnibus Budget Reconciliation Act (OBRA), which included legislation replacing the CPR charge system with the Medicare Fee Schedule (MFS) system. The MFS determines the payments physicians receive for any given procedure. The resource-based relative value scale (RBRVS) is a key component to estimating the fees on the MFS. The RBRVS is the "weight" Medicare

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30. These amendments include the Emergency Extension Act of 1985 (P.L. 90-107), P.L. 99-155, P.L. 99-181, P.L. 99-189, and P.L. 99-201 [26].

uses in its reimbursement formula—it allows Medicare to pay higher fees for more costly procedures. The three factors Medicare takes into account to estimate the RBRVS include the average physician's:

- Total work for a procedure—which includes the physicians' time, physical effort and skill, mental effort and judgment
- Practice expenses attributable to a procedure—including equipment, rent, and salaries for personnel
- Malpractice expenses attributable to a procedure.

The MFS allows no payment differentials between specialists and primary care physicians for performing the same procedure [27]. Therefore, some expect the MFS to decrease the incomes of surgeons and specialists and increase the incomes of primary care physicians because the MFS is created by averaging over primary care physicians and specialists performing the same services. Since 1983, the average annual rate of increase in physician payments has slipped to 11.1 percent, compared to a rate of increase of 20.8 percent from 1974 to 1983.

The OBRA of 1989 also includes other physician regulations. Volume performance standards (VPS) control the number of physician visits. If physicians' expenditures exceed the target, then reimbursement levels are reduced the following year to make up for the difference. Therefore, physicians have a reduced incentive to increase patient volume to increase their profits.

## **Medicare HMOs**

Medicare also offers an HMO option in some regions—an option that is expanding. By 1995, 74 percent of Medicare beneficiaries were in a region served by a Medicare managed-care plan [18]. Over one-third of HMOs participate as Medicare contractors. Before 1985, HMOs could serve Medicare enrollees only through cost-based (retrospective) contracts. Congress strengthened Medicare's contracting authority when it passed the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982. TEFRA allowed Medicare to enter into both cost-based (retrospective) and risk-based contracts with HMOs. Under a risk-based agreement, contracting HMOs receive fixed periodic payments from

Medicare. Payments equal 95 percent of the adjusted average per capita cost (AAPCC) of providing health care services to beneficiaries in the HMO's geographic area. The AAPCC is the actuarial cost of services Medicare would have paid if the beneficiary had received care under fee for service.

The AAPCC varies with several factors, including the beneficiary's:

- Geographic location
- Age
- Sex
- Institutional residence, e.g., nursing homes, rest homes, and mental hospitals
- Welfare program status.

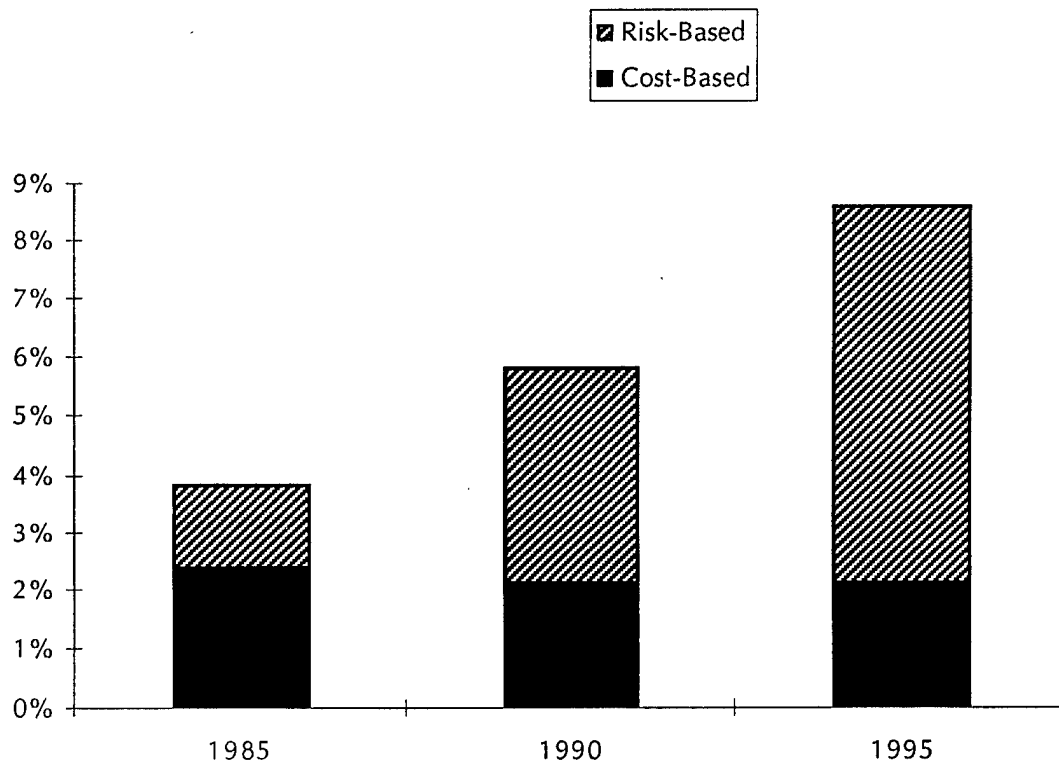
If the AAPCC payment is less than the costs incurred by the beneficiary, the HMO takes a loss, but if the payment is more than the costs, the plan realizes a "savings." The plan may use the savings in a number of ways, such as to reduce enrollees' premium expenses or to cover additional services. The plans may also place part of the savings in a fund to cover future losses. Furthermore, plans may choose to forgo the savings by accepting lower payments.

Beneficiaries give up choice of providers when they join an HMO. Medicare or the HMO has no obligation to pay for care received without HMO approval. Given this limitation, why do Medicare beneficiaries voluntarily join HMOs? First, HMOs usually cover more services than Medicare fee for service. Second, beneficiaries' health care costs are more predictable under the HMO option. And finally, HMOs typically have small specified copayments. Medicare HMO enrollment has increased slowly over time, growing from about 4 percent of beneficiaries in 1985 to 9 percent in 1995 (see figure 12).

Currently, only 2 percent of the beneficiaries are enrolled in cost-based HMOs, whereas 7 percent are enrolled in risk-based HMOs. Although this is a relatively small percentage of the Medicare population, it is steadily growing. During the past 10 years, Medicare HMO participation has more than doubled, with the majority of the growth

coming from risk-based enrollment. HMOs are playing a major role in the 1995 Medicare debate [27]. However, because 74 percent of Medicare beneficiaries could join HMOs, and only 9 percent have joined, HMOs are not a preferred choice.

Figure 12. Percentage of Medicare beneficiaries enrolled in HMOs<sup>a</sup>



a. Source: [28].

## Reforming Medicare

Several factors make Medicare a hot topic in 1995. First, both the administration and Congress want to reduce the deficit and achieve a balanced budget. It is likely that such efforts will involve cutting Medicare costs. Second, the Social Security and Medicare Boards of

Trustees have asserted that the Medicare, part A, Trust Fund will go bankrupt in 2002.<sup>31</sup> Although there are disagreements about the seriousness and immediacy of the problem, there is a general consensus that the Medicare Trust Fund faces severe financial difficulty in the coming decade. Finally, there is concern for the rapid growth in the share of federal spending devoted to health care expenditures.

If the administration and Congress are to meet their goals, they must reduce government expenditures. Figure 13 shows that in 1993 Medicare took up about 9 percent of federal expenditures. Many view Medicare as a special problem because it is an entitlement program. As such, the funding for Medicare increases automatically as program enrollment and expenses grow.

Balancing the budget will likely mean "cuts" in Medicare as well as other large expenditure categories. A budget cut often means a reduction in the growth of expenditures below the level of anticipated spending. Therefore, a cut in a program can mean that the budget for a program actually increases, but at a rate lower than current projections indicate. Currently, Medicare pays out about \$4,800 per covered person.

CBO projects annual Medicare expenditures to increase from \$176 billion in 1995 to \$286 billion by 2000 [30].<sup>32</sup> This translates into a 10.2 percent annual growth rate. Both the administration and Congress are forwarding plans to limit growth of payments, proposing cuts of projected spending of between \$124 and \$270 billion over

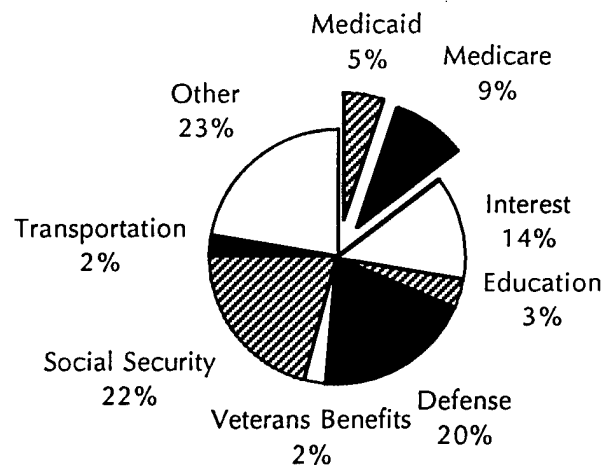
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31. The Social Security and Medicare Boards of Trustees annually report to Congress on the financial status of the trust funds. (Six people compose the Boards of Trustees: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two members appointed by the president and confirmed by the Senate.) In 1995, they reported the following [29]: The part A (HI) trust fund "will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range."

32. Projections vary. The Health Care Financing Administration (HCFA) projects \$190 billion in 1995 growing to \$293.5 billion in 2000 [16].

7 to 10 years.<sup>33</sup> The administration plan is more modest and gradual, yielding projected reductions of about \$124 billion over 10 years. The administration believes that these gradual cuts would balance the government's budget in 10 years rather than 7 years and keep the trust fund solvent at least through 2005.

Figure 13. Federal expenditures 1993<sup>a</sup>



a. Source: [4].

33. These estimates are based on data taken from HCFA projections. The prediction was based on projected expenditures of \$190 billion in 1995 growing to \$293.5 billion by 2000 [16].



Congress is considering several Medicare reforms, some deriving from historical Medicare management procedures, and some based on the current reform debate. The reforms include:

- Increasing revenues
- Reducing reimbursement rates to providers
- Increasing recipient cost sharing
- Restricting eligibility
- Establishing medical savings accounts (MSAs)
- Expanding managed care.

#### **Reforms based on historical Medicare management procedures**

*Increasing revenues.* Revenues for Medicare come from three different sources:

- Payroll taxes (pays for part A)
- General revenues—primarily income taxes (subsidizes part B)
- Part B premiums.

These revenue sources affect age groups differently. An increase in payroll taxes transfers income from the young to the elderly. An increase in general revenues, via a tax increase, affects both groups. An increase in the part B premium primarily affects the elderly. Some in Congress believe that increasing the part B premium can be considered a revenue increase, which in turn may be interpreted as a tax increase by some voters. Congress may decide to avoid the appearance of increasing taxes, or increasing costs to senior citizens.

*Reducing provider reimbursements.* Reduced provider reimbursements are politically palatable to many because they do not directly affect beneficiaries. Congress may be interested in reducing reimbursement rates further for all providers—from hospitals and physicians to nursing homes, hospice care, and labs—to generate a significant dollar savings.

However, reducing provider reimbursements is not painless:

- Some hospitals, particularly public institutions, have a disproportionate share of Medicare beneficiaries. A reduction in reimbursement rates may put extreme financial pressure on these hospitals.
- Providers may also try to recoup the losses on Medicare patients by increasing the costs to non-Medicare patients (i.e., cost-shift).<sup>34</sup>
- More physicians may decline to accept assignment, which will increase out-of-pocket costs to beneficiaries as they are asked to pay for more costs that Medicare will not cover.
- Providers may spend less time with Medicare patients, as a way of responding to lower reimbursement rates.

In addition, some providers may choose not to care for Medicare beneficiaries at all.

However, the approach of reducing provider reimbursement is not based on analysis of how reimbursement rates are set. We have a system of rates set by the MFS. The plans to cut provider rates do not indicate how the current Medicare Fee Schedule is flawed or how it fails to reflect actual costs of services. Although reducing provider reimbursement is one way to reduce costs, it is an ad hoc measure and may bring about indirect and undesirable consequences for both beneficiaries and providers.

*Recipient cost sharing.* Increasing recipient cost sharing would reduce utilization as well as reduce Medicare's costs directly. One proposal will raise the Medicare, part B, deductible from \$100 to \$150 [30]. In addition, there is some discussion in Congress regarding copays on services that previously lacked cost sharing—home health care, skilled nursing facilities, and clinical labs. Medicare's home health care program is a primary candidate. Its costs have been growing at a rate of 25 percent per year since 1988 and represent a growing part

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34. See study conducted by Lewin-VHI, Washington DC, reported in *The Washington Post* Business section, 5 Nov 1995.

of Medicare's budget [31]. For 1995, it was estimated to be 9 percent of Medicare spending, compared to 2 percent in 1980 [30].

According to Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation for the Department of Health and Human Services, the President will fight Congress' efforts to increase cost sharing in these areas [30]. In testimony in a Capitol Hill Briefing, Feder noted that the highest users of home health care are poor women—who could not afford copays.<sup>35</sup> At the same Capitol Hill Briefing, Representative Peter Deutsch (D) also shared concerns over reducing the amount spent for home health care. He views home health care as a substitute for more expensive inpatient care, a view substantiated with research from Helbing, Sangl, and Silverman [32].

An increase in cost-sharing for selected services, such as home health care, may leave some Medicare enrollees unable to pay for home care, which might increase Medicare's costs. Under PPS, hospitals have a strong incentive to discharge patients quickly. However, if the beneficiary is unable to afford home health care after a quick release from the hospital, he or she may not get needed care. This could increase Medicare's costs if the beneficiary then has to be readmitted to the hospital.

#### **Reform considerations based on current political debate**

*Medicare eligibility.* Restricting Medicare eligibility could reduce expenditures. Congress could further increase the retirement age—perhaps by tying Medicare eligibility to full retirement eligibility, which is increasing over time. They could also restrict eligibility by “means testing” income. Means testing is a method of determining

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35. Based on 1992 Current Population Reports data, 61.4 percent of women above age 65 have money income of less than \$10,000 annually, while only 30.4 percent of men fall in this category. Median money income for women above age 65 was \$8,190, while for men the median was \$14,548. These data are for those reporting money income, which is defined to include: money wages, net income from self-employment, social security, public assistance, income from estates or trusts, interest, rental income, veterans' payments, private pensions, and regular contributions of persons not living in the household [4].

Medicare eligibility or premiums that depend on the income of the senior. Under the current Medicare scheme, virtually all people age 65 or above—regardless of income—are Medicare eligible.

One proposal in Congress is to raise Medicare premiums for people with incomes of \$75,000 or more and couples with incomes of at least \$150,000 [33]. Although we are not sure what elements of income—interest income, social security income, earnings, etc.—will ultimately be included in the means test, relatively few seniors may be affected. In 1992, only 1.5 percent of seniors had money incomes above \$75,000.<sup>36</sup>

*Medical savings accounts.* The idea of MSAs has been considered as part of general health care reform. One Congressional plan has a special variant of an MSA for Medicare enrollees. Under this plan, seniors could elect to take a private health policy with a high deductible, somewhere from \$3,000 to \$6,000. The federal government would pay for this catastrophic health care policy with the person's Medicare benefit money, based on the AAPCC amount. Any leftover money from the AAPCC would go into an MSA for the individual [34]. People could also add money to their MSAs, although personal contributions would not be tax deductible, and interest earned on the account would be taxed.

Beneficiaries would be expected to draw on their MSAs to cover minor medical expenses—to use their MSA to pay for the high deductible for catastrophic insurance. If a beneficiary doesn't use all of the funds in the MSA during the year, the unused portions can be saved in the account for future medical expenses, or can be spent on other things. On the other hand, if a beneficiary incurs huge medical expenses, the catastrophic insurance coverage kicks in. Beneficiaries would not be taxed on money contributed by Medicare, as long as the money was spent to pay health care expenditures.

Proponents of MSAs believe they have two main advantages. First, MSAs will encourage beneficiaries to become price sensitive, which

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36. Figure based on 1992 Current Population Reports data for persons with money income, above the age of 65 [4].

will create price competition among providers. Second, MSAs will lower administrative costs by eliminating many small claims.

However, critics of MSAs contend that MSAs may be vulnerable to adverse selection. Adverse selection occurs with most types of insurance. It occurs whenever those most likely to have the adverse outcome purchase insurance to protect themselves from that outcome. In the case of MSAs, suppose the healthiest individuals are more likely to create MSAs. The least healthy individuals would choose to keep traditional insurance coverage. As less healthy consumers become concentrated in traditional health insurance, costs there would rise.

*Managed care.* Congress could make some changes to Medicare's HMO option that would make it more cost effective and enroll more beneficiaries. Under the current system, Medicare actually incurs greater expenses if beneficiaries enroll in HMOs than if they stay with the traditional fee-for-service benefit. This effect is the result of the HMOs' "favorable selection bias," that is, HMOs tend to attract healthier than average beneficiaries. Medicare pays HMOs 95 percent of the AAPCC. However, the Congressional Budget Office (CBO) estimates that the healthy beneficiaries actually cost HMOs about 86 percent of the AAPCC [28].

The CBO has considered three options to make Medicare HMOs more cost effective [28]. First, Medicare could include enrollees' health status in its computation of the AAPCC. Under this system, HMOs would receive less money for healthy enrollees. CBO estimates that including health status in the AAPCC formula would have reduced Medicare spending by \$900 million in 1995. Second, rather than spending their savings on additional benefits, HMOs could return a portion to Medicare. CBO estimates that if half of the savings were returned to Medicare, it would have saved \$640 million in 1995. Third, Medicare could set HMO capitation payments through competitive bidding. The bidding process could reduce Medicare's payments in competitive HMO markets.

Many elected officials are in favor of using managed care for Medicare. Some point to the success they believe managed care has had in the private sector in reducing costs. They also point to managed-care programs in such states as Arizona and Oregon, which are mostly

focused on Medicaid-eligible populations. They would like managed care to play a similar role in the Medicare program—reducing utilization and increasing the level of preventive care that seniors receive.

Other public representatives are skeptical about the role of managed care for Medicare. They claim that managed care won't save enough money to meet Congressional targets for reducing Medicare. Because the managed-care plans are likely to be optional for seniors, there may be some selection bias. That is to say, the least healthy Medicare beneficiaries—who would save Medicare more money if they enrolled in a managed-care plan—are likely to stay with fee-for-service coverage. Therefore, managed care may not save much money because more costly individuals may choose not to enroll in managed care, as shown by Hadley and Langwell [35]. And, if managed care fails to bring about substantial savings, other Medicare cuts may result.

In addition to these concerns, some people fear that HMOs have an economic incentive to reduce costs too far (i.e., an incentive to skimp on care). Congress is considering action on several bills that seek to regulate HMOs. One example is the Mothers' and Infants' Good Health Act, which addresses concerns that HMOs have been discharging mothers and newborns too soon after birth. This act allows mothers and new infants to spend more time in the hospital following birth than the HMO standard of one night. There are concerns that seniors may face similar problems with HMO standards that are driven more by profit motives than concern for patient well-being.

None of the proposals being discussed in Congress would make managed care mandatory for Medicare beneficiaries. Rather, they would be given an additional choice for their health care. Beneficiaries might receive a voucher for a given sum of money, which could be applied to pay for a variety of health care plans or traditional fee for service Medicare. The choice might be between private sector plans and traditional Medicare. The voucher would cover most of the costs of less expensive plans, with the beneficiary making up the cost difference if he or she chose a more expensive plan.

However, some people have voiced concerns about how a voucher system would work, and fear that it might be operated to cap Medicare costs. Under a voucher system, the government can limit its liability for

each senior rather than incur the costs of care—no matter how large—for each enrollee. This might eventually lead to seniors paying more out-of-pocket costs for health insurance, depending on how the voucher system works. Suppose, for example, the voucher is pegged to a specific dollar amount, which is allowed to rise by the overall rate of inflation measured by the Consumer Price Index (CPI). In recent years, the medical component of the CPI has grown faster than the CPI.<sup>37</sup> If this trend continues, the voucher amount would rise at a rate lower than medical costs and, hence, medical premiums.

In addition, even if the voucher initially covers the premium costs of traditional Medicare, the deductibles for hospital and physician services under traditional Medicare may rise over time, causing out-of-pocket costs to continue to rise. Under this scenario, it may be difficult over time for a typical senior, with a household income of \$25,000 a year, to afford the costs of traditional Medicare even if the voucher starts out at a relatively generous level.<sup>38</sup> If traditional fee-for-service Medicare becomes more expensive relative to managed care, seniors with low incomes may be forced into managed care with limited provider choices.

## Summary of Medicare trends

Medicare has assumed a very important role in the lives of our senior citizens. It is the primary health insurance for virtually everyone above the age of 65. Although it has a crucial role, seniors still pay for a substantial share of their health care costs out-of-pocket, either through direct payments or by purchasing MediGap insurance in the private market. The growth of Medicare spending has been relatively smooth over time, and has reflected the constantly (although slowly) increasing numbers of those above age 65, as well as the relatively

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37. The CPI Detailed Report, Bureau of Labor Statistics, Aug 1995, reports this trend.

38. In 1992, the mean money income of a household with the age of the householder above 65 was \$24,849. This includes all sources of money income (Social Security, interest income, pension income, etc.) combined for all members in the household. However, the mean income is considerably higher than the median income, which is \$17,160 [4].

high growth of the medical component of the consumer price index. The expected continuation of the aging of our population, especially when the baby boomers reach age 65, will stress our society's ability to pay for Medicare in coming years.

During an effort to balance the national budget, Medicare becomes an attractive target in the sense that it represents a large (and growing) pot of money. However, Medicare has a strong constituency—those who depend upon Medicare are politically active and well-organized. Managed care has been raised as a way to trim the growth of Medicare costs. Given the strength of support for traditional Medicare, it appears likely that voluntary enrollment into HMOs will be pushed for seniors, rather than mandatory enrollment. If seniors do not respond to encouragement to join HMOs, or if the initial managed care efforts do not yield the amount of savings desired, Medicare may face more substantive policy changes in the future.

## Medicaid

We now turn our attention to the Medicaid program, the other major public health care program. Medicaid has had a real impact on increasing access to care for portions of our nation's most vulnerable populations. Yet, despite the program's success, Medicaid is not a popular program compared to the general appeal of Medicare. It does not have a strong and politically powerful constituency. Most of its beneficiaries are children and cannot vote. All Medicaid beneficiaries are poor. Many elected officials view Medicaid as just another welfare program that promotes dependency and uses tax dollars unwisely.

Since its creation in 1965, Congress has adopted hundreds of changes to the Medicaid program. Some of these changes were enacted to expand coverage and benefits to increase beneficiaries' access to care. Other changes attempted to curtail federal and state Medicaid expenditures. Still others were passed to give states more flexibility in administering their programs or as a means of reducing federal financial participation in state Medicaid programs. Although Congress adopted a number of changes to the program early in its history, most significant legislative activity and consequent changes in Medicaid occurred during the 1980s and into the 1990s.



In this subsection, we outline the major changes in the Medicaid program and explore the impact of those changes on the health care industry. Two issues dominate the discussion of the Medicaid program: coverage levels and program costs. Over the course of Medicaid's history, the pattern that emerges is one in which pressures to increase coverage in terms of eligibility and service levels have contributed to continually increasing program costs. Medicaid costs also have been adversely affected by high rates of medical inflation, which have occurred throughout the market.

In response, Congress has relied on three types of reforms aimed at cost containment:

- Changes affecting provider reimbursement
- Changes affecting federal financial participation
- Demonstration authority for the states.

As we shall see in the discussion that follows, the results of these reforms in terms of containing Medicaid costs have been mixed and at best short-lived.

## **Overview of the Medicaid program**

Medicaid serves as an umbrella social program—part welfare and part health insurance—that provides medical assistance to a number of different populations, including low-income families, the blind, the disabled, and elderly persons in need of long-term (catastrophic) care. Each state is responsible for establishing eligibility standards, determining the type, amount, duration, and scope of services, setting payment rates, and administering their program.

There are, however, some minimum eligibility and service requirements. State Medicaid coverage must extend to all families covered by the Aid to Families with Dependent Children (AFDC) program and to all persons receiving cash assistance under the Supplemental

Security Income (SSI) program.<sup>39</sup> Federal legislation requires states to include the following basic services in their Medicaid programs:

- Inpatient and outpatient hospital services
- Physician services
- Skilled nursing facility services for persons age 21 or older
- Home health care
- Lab and X-ray services
- Early and periodic screening, diagnosis, and treatment for children
- Prenatal care
- Family planning services and supplies
- Medical and surgical dental care
- Federally qualified health center services
- Rural health clinic services
- Nurse midwife services
- Certified pediatric or family nurse practitioner services [36, 37, 38].

States may place limits on services based on medical necessity or utilization control. However, the amount, scope, and duration of service must be sufficient to reasonably achieve its purpose.

Medicaid is traditionally viewed as a state program, although federal financing is substantial. The federal government's dollar portion for each state's program is known as the Federal Medical Assistance Percentage (FMAP). The FMAP is based on a formula that compares the state's per capita income level with the national average. By law, the

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39. AFDC eligibility is based on a family's income, which must be below an income and assets threshold. Low-income women and children make up almost all the AFDC eligible. SSI provides cash assistance to low-income and disabled persons.

FMAP may be no lower than 50 percent and no higher than 83 percent. Wealthier states will have lower FMAPs.

If a state chooses to provide optional services under its Medicaid program, they receive matching federal funds for those services as well.<sup>40</sup> In addition, the federal government contributes funds toward the states' administrative costs, generally matching these costs at 50 percent. Because Medicaid is an open-ended entitlement program, the government is obligated to pay providers for all covered services received by Medicaid eligible persons.

### Program expansion and costs

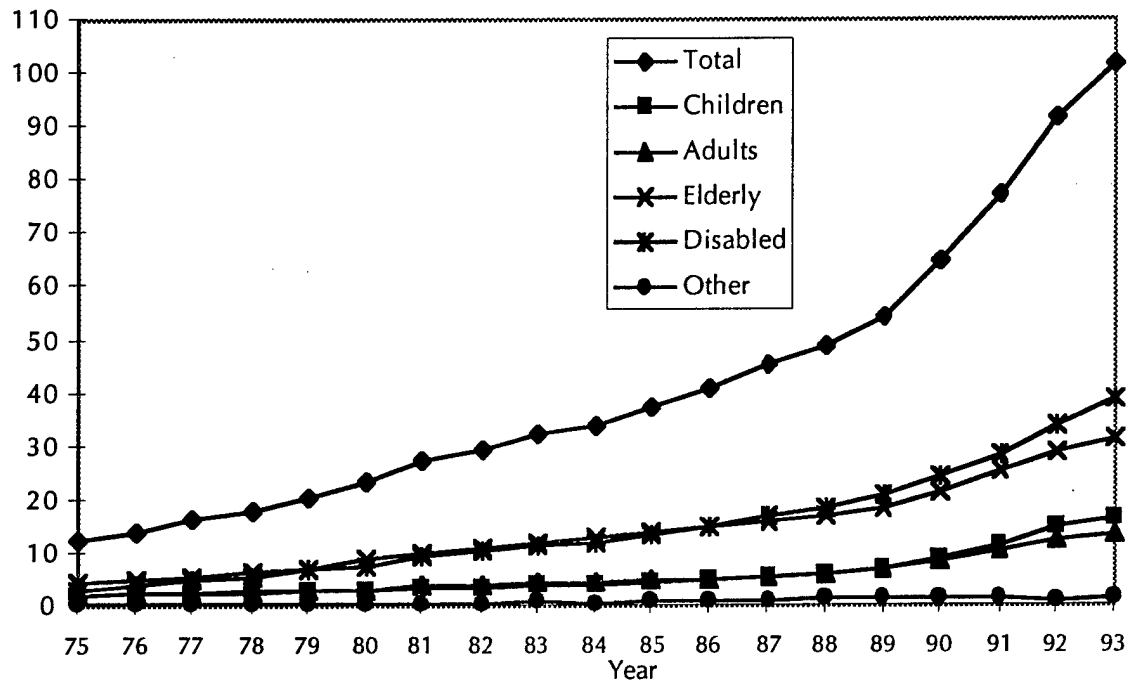
Medicaid program costs have increased steadily over time, with the increases becoming more dramatic in recent years. As shown in figure 14, total Medicaid medical assistance and administration expenditures have grown from approximately \$12.6 billion in 1975 to nearly \$131 billion in 1993.<sup>41</sup> Since 1970, Medicaid health care expenditures have risen at a slightly higher rate than Medicare expenditures. Public health care expenditures for Medicare had an average annual rate of change of 14.3 percent between 1970 and 1992. In comparison, public health care expenditures for Medicaid had an average annual rate of change of 15.6 percent from 1970 through 1992 [1].

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40. Examples of optional services include nursing facility services for the aged in an institution for mental disease, intermediate care facilities, care for the mentally handicapped, optometry services and eyeglasses, prescription drugs, TB-related services, and prosthetic devices [36].

41. Note that these data are from the HCFA-64 report, which provides actual expenditures made by states for which they are entitled to receive federal matching funds. The HCFA-64 report includes actual payments for services, additional payments to disproportionate share hospitals, and data for some jurisdictions that do not report data on the HCFA-2082 report. Appendix B provides the data in table format.

Figure 14. Medicaid medical assistance payments and administration expenditures: FY 1975–1993



Levels of growth have not been uniform: three trends in Medicaid expenditures are noted in the literature. Between 1975 and 1981, Medicaid expenditures increased at an average annual rate of 14.2 percent [39]. The growth rate slowed in the 1980s to more moderate annual costs increases averaging about 10 percent [6, 37, 40, 41, 42]. The pattern changed again between 1989 and 1992, during which time Medicaid expenditures grew at an average annual rate of nearly 20 percent and were quite volatile. From 1990 to 1992, Medicaid grew at an average annual rate of 28 percent. The program's high growth rate between 1990 and 1992 far outpaced that experienced in the private health sector and the growth rates in Medicare, which were 7.2 and 10.7 percent, respectively [37]. In FY 1993, the rate of growth in Medicaid expenditures slowed to only 9 percent [40].

Clearly, Medicaid expenditures have been a constant concern for both the federal and state governments. Indeed, the tendency of Medicaid to exceed projected costs year after year is perhaps the best known fact about the program. The most recent dramatic increases are particularly troublesome given that government estimates had not predicted such high levels of growth.<sup>42</sup> Why have Medicaid costs increased so dramatically over time? Three policy-related factors are typically cited in studies that examine Medicaid costs:

- Growth in number of persons eligible for Medicaid
- Increases in provider payments
- Special financing arrangements used by the states to increase federal matching payments.

### **Medicaid eligibility**

In figure 15, we show the number of Medicaid users by eligibility group from fiscal years 1975 through 1993.<sup>43</sup> Traditionally, eligibility for Medicaid has been based on standards set for other federal income maintenance programs. Eligibility of low-income families, particularly pregnant women and children, generally has been tied to standards set for the receipt of cash assistance through the Aid to Families with Dependent Children (AFDC) program. However, Congress severed the tie to AFDC eligibility in the late 1980s and mandated coverage for pregnant women and children under age 6 in families at 133 percent of the federal poverty level and all children under age 19 in families at 100 percent of the federal poverty level.

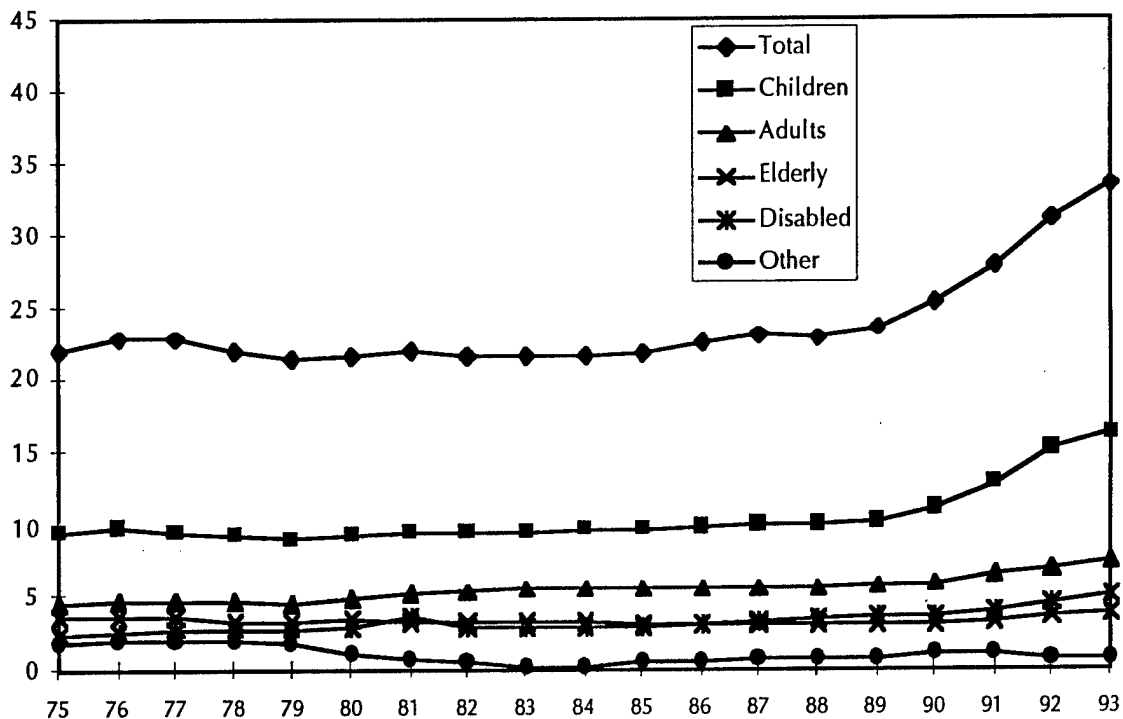
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42. For example, the Office of Management and Budget had predicted a 12-percent increase in expenditures for 1992. In actuality, Medicaid expenditures increased by 27 percent [37]!

43. We also provide data on Medicaid users in table format in appendix B.

For the aged and disabled, Congress has focused coverage on individuals receiving cash assistance through the Supplemental Security Income (SSI) program and certain SSI-related groups.<sup>44</sup>

Figure 15. Number of Medicaid users (in billions) by eligibility group, FY 1975–1993



44. Congress adopted this approach to defining eligibility requirements fairly early in the program's legislative history. Congress mandated states to tie Medicaid-eligibility requirements to the state's income standards for AFDC under the Social Security Amendments of 1967 (P.L. 90-248). Congress redefined the Medicaid-eligible population to include those persons receiving SSI under the 1973 combined Social Security and Supplemental Income Amendments (P.L. 93-66 and 93-233). In addition, Congress expanded the level of benefits to include care received in intermediate-level facilities for the mentally handicapped, thus implicitly extending coverage to that population. However, in an attempt to ease the increasing financial strain on the program, Congress eliminated Medicaid's program goal of comprehensive coverage of the poor [6].

By 1975, the total number of Medicaid recipients had reached about 22 million—nearly twice the number of recipients in 1968—and program costs had quadrupled [10, 39]). In 1968, total federal and state payments for Medicaid were \$3.45 billion. In 1975, Medicaid costs were over \$12 billion [10]. The states responded by adopting strategies to limit increases in the number of Medicaid recipients in an effort to contain cost increases. As we shall see, however, program initiatives aimed solely at stemming the Medicaid-eligible population have not been successful in containing costs.

Figure 15 shows that the states were able to maintain near-zero growth rates in the total number of Medicaid recipients from 1975 through much of the 1980s [39]. Several factors affected the number of Medicaid users during this period. First, the states did not index income eligibility standards to inflation during the mid- and late-1970s, contributing to a decline in the number of Medicaid users from over 22.8 million users in 1976 to 21.6 in 1980 [6]. Second, the states exercised their latitude in setting standards for AFDC and SSI eligibility. Income eligibility thresholds for state AFDC programs decreased from an average of 75 percent of the poverty level in 1975 to 53 percent of the poverty level in 1980 [43, 44].

As a result, the *percentage* of the poor who were eligible for Medicaid decreased and the *number* who were eligible remained about the same. However, Medicaid payment levels continued to be adversely affected by high inflation, increasing at an average annual rate of 14.2 percent between 1975 and 1980 [6, 39]. Average Medicaid payments per user nearly doubled from \$556 in 1975 to \$1,079 in 1980 [1]. It was not until the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (P.L. 97-35) that the rate of growth in the number of Medicaid users *and* expenditures was successfully limited.

OBRA 1981 gave the states greater flexibility over the scope and design of their Medicaid programs. In particular, OBRA loosened federal guidelines directing states' definitions of "medically needy persons." Among the most important changes were provisions limiting coverage under AFDC for working families. OBRA set new limits on both income and resources for AFDC and Medicaid eligibility. OBRA also placed a ceiling on gross income for AFDC families at 150 percent of each state's income eligibility standards for public

assistance, and prohibited eligibility for cash assistance and Medicaid for first-time pregnant women with no other children before the sixth month of pregnancy. In addition, the law rescinded mandatory coverage of children between 18 to 21, giving states the option to provide coverage to children between age 18 and 21 and of setting limits on coverage for children in two-parent families [45].

As a whole, the provisions of OBRA 1981 stand as the most restrictive in Medicaid history. As shown in figure 15, growth in the number of users remained fairly flat, hovering around 21.6 million recipients through 1984. By lowering eligibility standards, Medicaid covered a smaller proportion of the poor and near poor in 1985 than in 1980, with coverage levels declining from 53 percent in 1980 to 46 percent in 1985 [44]. Increases in Medicaid expenditures slowed to an annual rate of 8 percent. Higher prices accounted for a 10-percent rate of increase, but were moderated by a 2-percent decrease in utilization [6].

In 1984, the legislative tide receded from its previous support of the Reagan administration's initiatives to reduce federal spending, especially for programs serving the poor. In the Medicaid arena, Congress enacted a number of reforms that effectively rescinded the OBRA 1981 eligibility restrictions and mandated unprecedented expansions.<sup>45</sup> These expansions are particularly notable given that the OBRA 1981 terminated benefits for working poor women and children and significantly curtailed coverage of other beneficiary categories. Beginning with the Deficit Reduction Act (DEFRA) of 1984 (P.L. 98-369), major eligibility expansions for women and children occurred no fewer than seven times between 1984 and 1990. Overall, these legislative changes increased both optional and mandated coverage of low-income pregnant women and children generally not otherwise eligible for cash-assistance benefits. Among the most notable pieces of legislation are OBRA 1986 which severed the historical link between Medicaid and AFDC programs, giving states the option to cover poor women with incomes up to the federal poverty level but who were not AFDC eligible. OBRA 1989 further required states to

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45. See appendix C for a listing of Medicaid eligibility reforms from 1984 to 1990.



adjust their thresholds to 133 percent of the federal poverty level and to cover children up to six years of age [46].<sup>46</sup>

The Medicaid program expansions during the mid- to late-1980s were unprecedented in scope, opening the doors to coverage to many poor people who previously were ineligible. They contributed to an increase in the number of Medicaid users, particularly among low-income children. Children have consistently been the single largest group of Medicaid users and represented about 50 percent of Medicaid users in 1993

Compared to children, low-income adults, the disabled, and the elderly make up lesser proportions of the Medicaid populations. Over time, low-income adults have ranged in proportion from one-fifth to one-fourth of Medicaid users: they represented 22 percent in 1993. The low-income disabled have increased gradually from 11 percent of the Medicaid users in 1975 to 16 percent in 1993. And the low-income aged have decreased from 16 percent of Medicaid recipients in 1975 to 11 percent in 1993. These subpopulations also have experienced growth in numbers since 1989, but not as dramatically as the children.

The increase in low-income elderly Medicaid users follows the adoption of the Medicare Catastrophic Coverage Act of 1988, which required states to pay premiums, deductibles, and coinsurance for Medicare beneficiaries with incomes below federal poverty levels who do not otherwise qualify for Medicaid. When Congress repealed the Catastrophic Coverage Act, it left these provisions in place. Consequently, Medicaid essentially provides Medigap-type coverage to persons who are eligible for both Medicare and Medicaid. Medicaid coverage for the disabled was extended under OBRA 1989, requiring states to pay Medicare, part A, premiums for working disabled with incomes below 200 percent of the federal poverty level and with resources less than twice the maximum allowed under SSI.

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46. All states were brought into compliance with OBRA 1989 as of April 1990.

Historically, payments for the low-income elderly and disabled have represented a large proportion of total Medicaid payments (see figure 16).<sup>47</sup> While nearly two-thirds of Medicaid recipients are from AFDC families, their program costs represent about one quarter of all Medicaid payments. In contrast, the payments for the low-income elderly and the disabled account for nearly three-quarters of Medicaid expenditures. The relationship between Medicaid spending and eligibility levels over time is well established in the literature [37, 40, 41, 42, 47]. The results of this research have shown that total Medicaid expenditures for each eligibility group have increased significantly as the group's enrollment increases.

However, to what extent did the eligibility expansions of the late 1980s contribute to the dramatic increases in program expenditures between 1989 and 1994? In particular, we are interested in the impact of the eligibility expansions affecting low-income infants, children, and women given that these groups made up a significant portion of the growth in total Medicaid recipients after 1988. Recent work by Wade and Berg [37] estimates that low-income infants, children, and pregnant women accounted for only 9 percent of expenditure growth from 1988 to 1992. Based on this finding, eligibility expansions do not appear to be the driving force behind the more recent growth in Medicaid expenditures. What were the driving forces? As we will see in the next two subsections, the evidence indicates that changes in provider payments and in the rules governing federal financial participation levels have had a significant effect on the increases in Medicaid expenditures.

### **Provider payments**

Congress has sought to attain some level of cost containment in the Medicaid program via the authorization of several initiatives:

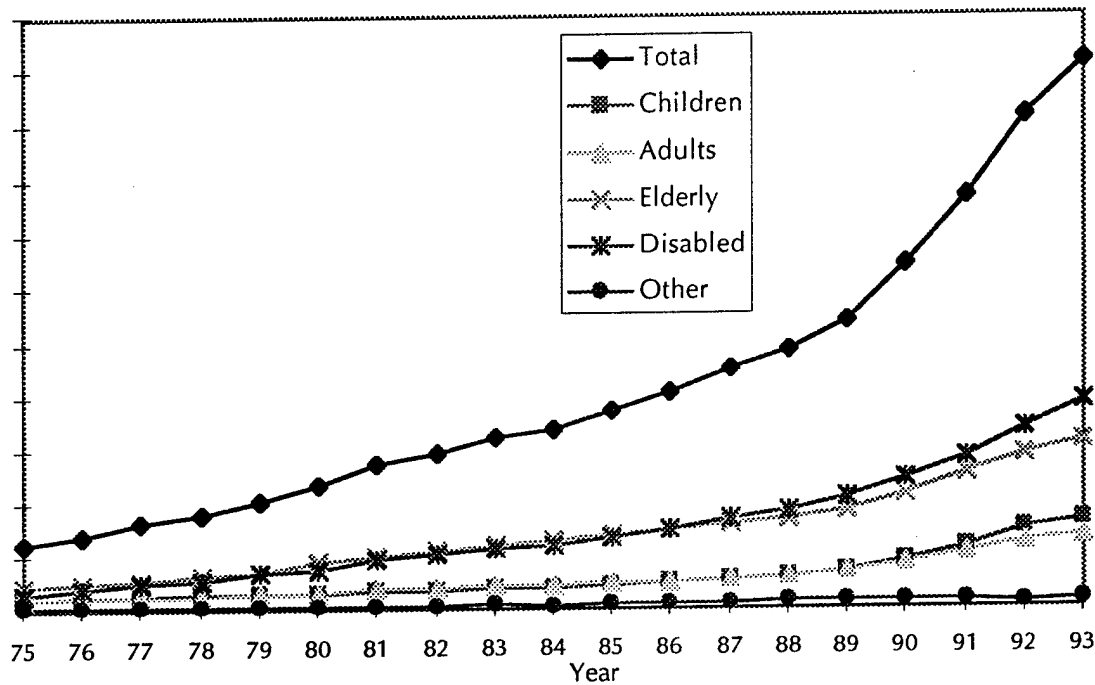
- Limitations on services

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47. Note that these data are from the HCFA-2082 report, an annual state report that presents summary data on eligibles, recipients, services, and expenditures for a federal fiscal year. Payment amounts reflect the amount paid for claims adjudicated during the year. We also provide the payment data in table format in appendix B.

- Limiting payment levels
- State demonstration programs testing alternate payment methods and managed-care strategies.<sup>48</sup>

Figure 16. Medicaid payments (in billions) by eligibility group, FY 1975–1993



Within the context of both federally mandated and optional services, states have had the ability to contain costs by restricting the number and/or type of services covered under Medicaid, such as the number of visits, the number of bed days, the types of procedures, requiring prior authorization for certain services, and the use of utilization review. The practice of limiting the number of visits and the number of hospital days has become more prevalent among the states during

48. In the following discussion, we draw on historical information provided by Davis et al. [6]. We note other sources where appropriate.

the 1980s. If a patient exceeds the limits, Medicaid may not cover the entire cost of care. Costs exceeding Medicaid payments become either bad debt or charity care.

From 1965 through 1981, Congress required the states to tie their Medicaid hospital payments to Medicare reimbursement principles. Initially, Medicare and Medicaid reimbursed hospitals based on charged costs. In 1972, the programs shifted to a reasonable cost reimbursement policy under section 223 of the 1972 Social Security Act Amendments. Section 223 authorized Medicaid (and Medicare) to disallow any costs it deemed medically inefficient and unnecessary.<sup>49</sup>

Section 222 of the 1972 amendments authorized the development of state demonstration programs aimed at containing health care costs. As a result of this legislation, several states actively sought to regulate health care costs by setting up rate-setting agencies. By 1982, sixteen states had implemented either mandatory or voluntary regulatory programs targeted at controlling Medicare and Medicaid expenditures for hospital care. An evaluation of the mandatory rate-setting programs in six states<sup>50</sup> found that the programs constrained hospital cost increases to 11.2 percent in comparison to an average increase of 14.3 percent in those states without programs [48].

The Medicare and Medicaid cost containment strategies initiated under sections 222 and 223 were part of the evolution in social health care policy and, more generally, in the national health care system. First, they indicated a willingness by Congress to take a more active regulatory role in overseeing the Medicare and Medicaid programs. The state experiences, in particular, demonstrated that a regulatory

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49. Initially, section 223 regulated the allowable amount for routine costs per inpatient bed day. Routine costs include charges for room, board, and nursing services. By focusing only on setting allowable amounts for routine costs, those costs driven by case mix complexity were still allowed to vary freely. Refinements to the allowable amount calculations in subsequent legislation include adjustment for capital costs, labor, and educational programs at teaching hospitals.

50. The six states are Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington.

approach can be effective in dealing with hospital cost inflation. In addition, both the state demonstration programs and national experience with redefining "allowable" costs provided new sources of data for further research and development of payment structures.

OBRA 1981 marked a departure from tying Medicaid hospital payments to Medicare reimbursement rules. OBRA granted the states greater flexibility in developing and initiating cost-containment measures with respect to their reimbursement systems. These provisions included:

- A repeal of hospital reimbursement based on reasonable cost and a requirement to develop and implement new reimbursement schedules for hospital care (known as the Boren Amendment)
- A modification to the "freedom of choice of provider" provision that allowed states to mandate use of preferred providers (section 1915 waiver)
- A repeal on the provision limiting state use of HMOs.

Under the Boren Amendment, Congress essentially decoupled Medicaid hospital reimbursement levels from the Medicare program and gave the states much more flexibility to determine their own payment methods as long as the state's plan met three basic requirements. The state must ensure that its rates:

- Are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities
- Are reasonable and adequate to ensure that Medicaid recipients will have reasonable access to inpatient hospital services of adequate quality
- Take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs [49].

As Medicare switched to using the Prospective Payment System, most states developed their own Medicaid payment methods, although some retained the old Medicare payment principles of reasonable

cost. Since the Boren Amendment, more than 30 lawsuits have been filed against the states [37]. These lawsuits have challenged the procedures by which a state sets payment rates, the substantive reasonableness and adequacy of the rates, and states' definitions of the terms *efficiently* and *economically* [49].

In most of the resolved cases, providers have prevailed. The courts have required states to raise the level of Medicaid payments and to make retroactive payments to facilities. Some states in which Boren cases have not been filed have increased their reimbursement levels in hopes of avoiding lawsuits. In short, while intended to give states flexibility to contain costs, providers have effectively sought relief in the form of higher payment rates under the Boren Amendment via the courts. The measured effects of the Boren Amendment on state-level Medicaid expenditures from 1984 to 1992 are both positive and statistically significant [37]. Boren Amendment cases generally are associated with an increase in inpatient, nursing facility, and total Medicaid expenditures. These expenditures are more often associated with care for the blind, the disabled, and the aged. Therefore, the impact of Boren cases tends to be greater for total expenditures for blind, disabled, and aged people than for adults and children.

Although there have been prepaid health plans in Medicaid since the 1960s, OBRA 1981 gave states greater flexibility to design and implement managed-care programs under section 1915(b) of the Social Security Act.<sup>51</sup> By February 1993, 36 states and the District of Columbia had one or more managed-care programs in place for their Medicaid beneficiaries.<sup>52</sup> An additional 13 states were in the process of developing some variant of Medicaid managed care and expecting to implement their programs by January 1994.<sup>53</sup> Consequently, as of

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51. In most cases, states must obtain a waiver from HCFA to develop managed-care programs. With HCFA approval, states also can experiment with new approaches to health care delivery through research and demonstration projects authorized under section 1115 of the Social Security Act.

52. This means the state had at least one managed-care provider serving some Medicaid clients within a target population.

January 1994, only the states of Alaska and Wyoming were without some sort of Medicaid managed-care program [50].

The types of managed-care programs vary in nature from fully capitated to partially capitated to fee-for-service, primary care case management. States tend to target AFDC recipients and related populations with their managed-care programs. States have found that the AFDC and AFDC-related population tend to more closely resemble patients in existing managed-care practices and do not require the same special health services as the SSI population. In addition, the AFDC population tends to have the most access problems. By using managed care, states hope to ensure that these populations will have better access to more cost-effective, preventive services, avoiding the need for more costly services later on.

Medicaid managed-care demonstrations established in the early 1980s offered opportunities for modest savings and enhanced control of program expenditures without adversely affecting quality, access, or satisfaction for beneficiaries [51]. However, most of these programs target populations in select areas of the state. Only Arizona has a statewide, mandatory, Medicaid managed-care program. As states expand their Medicaid managed-care programs, they will face a number of new challenges. The largest ones involve establishing the required infrastructure to support their managed-care systems. The states need to establish comprehensive data collection for monitoring access, utilization, and quality of care. In addition, states must implement appropriate monitoring systems to identify providers who may be vulnerable to financial risk and underservice. Only time will provide the outcomes.

#### **Changes affecting federal financial participation**

Paying the Medicaid bill has become a heavier burden for both the federal government and the states. In recent years, the states have experienced large disparities between the growth of the Medicaid program and that of their budgets. For most of 1980s, state revenues and

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53. The 13 states are Idaho, North Dakota, South Dakota, Nebraska, Oklahoma, Texas, Arkansas, Mississippi, Georgia, Delaware, Connecticut, Vermont, and Maine.

state-only Medicaid expenditures had increased at comparable levels of 9 to 10 percent. Beginning in 1988, however, state revenue growth slowed to about 7 percent, while state-level Medicaid spending increased at about 19 percent [40]. By the end of the 1980s, Medicaid represented the fastest growing component of state budgets.

In table 1, we show Medicaid as a share of state government expenditures in 1987 and 1990. In 1987, over half the states had Medicaid expenditures representing less than 10 percent of their total state budget, although the national average was 10.2 percent. By 1990, only 13 states maintained Medicaid spending levels below 10 percent of their total budgets—states mostly in the Midwest and western regions of the nation. The average state share had increased to 12.4 percent.

From 1987 to 1990, about two-thirds of the states experienced double-digit increases in the share of their state budgets spent on Medicaid. The states with the largest Medicaid programs in 1987 (Rhode Island and New York) maintained that distinction in 1990 but did not experience high rates of growth. In contrast, the states with smaller Medicaid programs in 1987 (e.g., Alabama, Mississippi, West Virginia, Texas, Wyoming, and Alaska) tended to experience the highest rates of change in program spending.

States entered the 1990s with declining fiscal balances, despite having raised taxes. The new federal mandates in Medicaid required states to expand their programs in nearly all cost areas: benefits, eligibility, and administration. The federal mandates placed increased fiscal burdens on the southern states. These states generally had the most meager Medicaid benefit packages, less state oversight, less expansive AFDC and SSI eligibility, and a higher share of families with incomes under the poverty line [52]. By the same token, many states also wanted the federal government to allow them more flexibility in extending coverage levels for pregnant women and children. Congress granted the states this flexibility when it decoupled Medicaid eligibility from AFDC eligibility under OBRA 1986.



Table 1. Medicaid spending as a share of total state spending<sup>a</sup>

State	1987 <sup>b,c</sup> (10.2%)	1990 (12.4%)	% Change (22.5%)
Connecticut	8.6	10.2	18.8
Maine	14.6	14.9	2.0
Massachusetts	9.7	15.2	57.1
New Hampshire	12.8	15.4	21.1
Rhode Island	17.9	19.1	6.7
Vermont	10.4	11.9	14.9
Delaware	5.4	5.9	10.5
District of Columbia	9.3	n/a	n/a
Maryland	9.2	10.2	10.2
New Jersey	11.7	13.7	17.4
New York	17.6	18.0	2.6
Pennsylvania	11.7	12.2	4.4
Illinois	10.6	11.9	13.1
Indiana	12.6	16.0	26.9
Michigan	10.7	16.0	49.6
Ohio	11.5	13.3	15.6
Wisconsin	10.2	12.9	26.4
Iowa	6.4	8.9	38.4
Kansas	6.9	8.6	25.2
Minnesota	11.1	14.2	28.5
Missouri	8.8	10.4	18.3
Nebraska	9.6	11.3	17.8
North Dakota	13.6	11.5	-15.5
South Dakota	10.8	13.8	27.9
Alabama	7.8	11.3	45.7
Arkansas	10.3	13.2	28.3
Florida	8.3	10.6	27.8
Georgia	11.5	12.7	9.9
Kentucky	9.5	12.2	29.2
Louisiana	11.9	15.5	30.1
Mississippi	10.5	14.9	41.7
North Carolina	9.3	11.5	24.3
South Carolina	7.7	9.8	26.4
Tennessee	13.4	18.1	35.5
Virginia	7.5	8.2	9.4
West Virginia	7.6	12.3	61.2

Table 1. Medicaid spending as a share of total state spending<sup>a</sup> (cont'd.)

State	1987 <sup>b,c</sup> (10.2%)	1990 (12.4%)	% Change (22.5%)
Arizona	n/a	10.7	n/a
New Mexico	7.1	7.3	2.1
Oklahoma	10.4	11.9	14.8
Texas	4.6	13.0	181.1
Colorado	8.9	11.0	23.8
Idaho	6.3	8.2	30.3
Montana	9.4	9.8	4.1
Utah	7.8	8.4	8.4
Wyoming	2.4	4.5	88.0
California	10.1	10.7	5.7
Nevada	8.8	n/a	n/a
Oregon	4.8	7.5	56.9
Washington	8.9	10.7	19.3
Alaska	2.2	4.2	86.9
Hawaii	5.8	5.5	-6.2

a. Source: [52].

b. Data are from the State Expenditure Survey and the National Association of State Fiscal Officers.

c. State fiscal years.

Although state Medicaid costs soared in the 1980s, the Medicaid financing system allowed states to use a number of special financing arrangements to increase federal support for their programs. These revenue-enhancing mechanisms include disproportionate share hospital (DSH) payments, provider-specific tax and voluntary donation (T&D) programs, and intergovernmental transfers. Under these mechanisms, the state either imposes a tax on providers or solicits voluntary donations for the state's Medicaid program. The state then returns the funds to the same hospitals in the form of DSH payments, triggering matching payments from the federal government. If the matching federal funds went directly to the hospitals, then the hospitals effectively collected more money, with all of it coming from the federal government and none from the state. If the state received the matching federal funds, it could reimburse hospitals amounts equal to the original tax and donation and then keep the remaining funds for other purposes. The mechanism essentially permits the state to

generate additional matching federal funds without placing an additional fiscal burden on the state [40, 52, 53, 54, 55].

While these special financing arrangements were available to the states throughout the 1980s, it was not until the early 1990s that states intensified their efforts to take advantage of these strategies. The effect on federal Medicaid costs was significant. In only two years, DSH payment expenditures rose from less than \$1 billion in FY 1990 to \$17.4 billion in FY 1992, representing about \$1 of every \$7 Medicaid spent on medical services [40, 54].

To stem the rising use of DSH payments, the Congress placed spending caps on the financing mechanism in 1991. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendment contains the following provisions:

- Limits DSH payments to a 12-percent national target
- Eliminates federal matching funds for all voluntary provider donations
- Limits provider-specific tax revenues to not more than 25 percent of the state's share of federal Medicaid expenditures [40, 52, 54].

The legislation did not impose any limits on intergovernmental transfers and actually prohibits HCFA from issuing new regulations affecting the allowability of such transfers. States use this mechanism to transfer tax dollars from local governments and state/county hospitals to the state Medicaid agency. The Medicaid agency then uses the funds to make payments to contributing providers and collect matching federal dollars on the transferred amount [40]. Because the Voluntary Contribution Act has limited provider taxes and ended voluntary provider donations, many states have reportedly increased their use of intergovernmental transfers [56].

## **Medicaid reform: the proposals**

Like most welfare-related programs, Medicaid is widely viewed as a program in need of reform. However, consensus ends at this point. The debate on how best to reform the program is deeply divided both

along party lines and within party ranks. At issue are basic questions of policy design. How do we define the problem? Who would be helped by specific proposals, and how much? Which design is the most effective?

At this time, the central concern defining the debate on Medicaid is how to structure the program in terms of funding and administration. Political pressure is particularly strong at the federal level, where the overall emphasis is on balancing the federal budget. Various proposals have been offered over the years, including federalizing Medicaid, splitting the Medicaid program, and converting to a block grant. In this section, we will outline the basic design of each proposal and examine the advantages and disadvantages associated with each.<sup>54</sup>

#### **Federalize the Medicaid program**

Currently, the federal government and states share responsibility for funding and administering the Medicaid program. Most funding comes from the federal government, while the states are mainly responsible for administering their programs. One alternative is to shift the entire responsibility for financing and administering the program to the federal government with no state involvement. This proposal includes establishing a uniform national Medicaid benefit and eligibility criteria. The idea to federalize the Medicaid program originated from the Reagan administration in the early 1980s.

Those in support of federalizing the Medicaid program argue that the design would allow better control of medical costs. As the sole purchaser of medical services for Medicare and Medicaid, the federal government would have more bargaining power to obtain lower prices on services. In addition, a federal Medicaid program would establish a uniform benefit and eligibility requirement across states, essentially achieving equity among beneficiaries and ending the migration of persons from state to state in search of higher benefits.

Opponents of federalizing Medicaid contend that defining a uniform benefit on a national scale is just too hard and too complicated to implement. If the federal government set a more generous benefit

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54. We obtained the material for this section largely from [12] and [15].

scale than the current average, it would result in higher total costs. Even maintaining the current benefit levels is associated with higher federal costs because the federal government would have to pay for the costs previously covered by the states. Alternatively, the federal government could adopt a lesser benefit level that the states could supplement if they wanted to provide more coverage. Of course, if states choose to supplement the federal program, the uniform benefit would no longer exist.

In addition, variations in the cost-of-living across localities would have to be taken into account. Opponents contend that the federal government would experience serious difficulties developing a program that took advantage of local circumstances to achieve maximum efficiencies. Many critics of the current system contend that we should focus our energies on restructuring the incentives for states, providers, and recipients to promote better use of Medicaid resources rather than undertake a major reorganization that may do more harm than good.

#### **Splitting the Medicaid program**

A second alternative is to split responsibility for the Medicaid program by the type of service: primary and acute care versus long-term care. Under this proposal, the federal government would fund and administer one program, and the states would take the other. For example, the federal government would fund and administer acute and primary care, while the states would take long-term care.

Splitting the Medicaid program by service would entail splitting the beneficiary population. Acute and primary care programs provide basic care to low-income individuals and children, and long-term care covers the elderly and the disabled. Like the proposal to federalize Medicaid, this proposal includes establishing a uniform national Medicaid benefit and eligibility criteria for the federally run program. Eligibility levels would be based on financial need and not tied to cash assistance programs. States would be granted much more flexibility to develop innovative ways to deliver long-term care. Splitting the program also would clarify state and federal responsibilities, and it would eliminate interstate inequities in acute and primary care by

establishing a uniform benefit and eligibility requirements and severing ties to cash assistance programs.

On the other hand, if the split of responsibility were to be reversed, the federal government would assume control of long-term care. Medicaid already is the predominate purchaser of long-term care in the nation and essentially shapes the long-term market. Adding this responsibility to that of Medicare would capture most of the care for the elderly and for long-term care.

However, splitting the program is not necessarily budget neutral for the states or for the federal government. If a national benefit is created, there is a question of whether local service systems would be able to provide the required services. Variations in the capacity of local medical resources would have a significant effect on the ability of the federal government to implement its program.

#### **Transform Medicaid into a block grant**

The most popular proposal in the current political climate is to convert the Medicaid program into a block grant. Block grant arrangements tend to be broad in scope, give the states more flexibility, and allocate funds on the basis of a statutory formula. Federal payments are made in the form of a once-a-year, lump sum amount. Block grants are associated with a variety of goals; they can:

- Encourage administrative cost savings
- Decentralize decision-making
- Promote coordination
- Spur innovation
- Target funding
- Control federal expenditures [57].

#### **Medicaid reform: the current debate**

Medicaid is one of many programs currently on the federal budget chopping block. Congress proposes to reduce projected Medicaid spending by \$182 billion during the next 7 years as part of a plan to

balance the federal budget by 2002. Proposed changes for Medicaid include capped federal contributions, potentially reduced payments to providers, and more managed care. The GOP plan calls for changing the Medicaid funding process into a block grant—MediGrant. Under a block grant system, each state would receive a single lump sum payment from the federal government. Each state would then decide how to combine its grant money with state funds to meet the health demands of its needy citizens.

Changing the Medicaid funding mechanism to a block grant will entail dramatic changes to the structure of the program. Under the proposed block grant structure, Medicaid would lose the program's individual entitlement status, which guarantees coverage to all persons meeting eligibility requirements. The major issues defining the debate on the specifics of the MediGrant proposal are the degree of state flexibility and the formula for determining the federal payment amount [58].

#### **State flexibility**

The block grants idea appeals to many governors who prefer more flexibility to shape their Medicaid programs. The GOP proposed legislation would repeal federal eligibility and coverage requirements. Each state would design a plan including eligibility requirements, coverage levels, and administrative guidelines. States would not have to guarantee that anyone meeting the requirements would receive benefits; the entitlement feature of the program would end.

A number of Congressional members have questioned the wisdom of revoking the entitlement nature of the Medicaid program. Republican Senator John H. Chafee of Rhode Island has successfully led efforts to moderate the Senate's proposal, restoring the entitlement provision for pregnant women, children age 12 and under, and the disabled [59]. It remains to be seen how the conference members will deal with this major difference between the Senate and House versions of the legislation.

The proposal imposes several requirements on the states to receive MediGrant funds. First, states must contribute a certain level of their own funds to obtain access to MediGrant dollars. Second, the proposal

requires states to spend MediGrant funds on health care for low-income people; they may not divert MediGrant dollars for other purposes. Finally, the proposal requires states to spend a specified percentage of funds on pregnant women, children, nursing home residents, the low-income elderly, and the low-income disabled. States would submit their plans to the Secretary of Health and Human Services for approval. The proposed legislation does not specify the extent of the DHHS authority to act if it disapproves a state's plan.

### **MediGrant distribution formula**

A critical issue in changing to a block grant structure is how to divide the funds among the states. What is the MediGrant distribution formula? There has been wide disagreement across all political spectrums over the funding formula. The formula definition will determine which states are the winners and losers. One approach is to benchmark future funding levels against a baseline year. Republican leaders have proposed using 1994 funds as a baseline. However, wide disagreement ensued over how to account for future population growth. The Government Accounting Office [57] has cautioned that basing block grants on the previous formula for determining the FMAP may not be fair because it does not necessarily reflect need, ability to pay, or variations in state services.

The compromise proposal includes a transition year (fiscal 1996) in which all states receive an increase of 7.24 percent. Beginning in fiscal 1997, state funding levels will be set using a complex model; however, all states are guaranteed at least a 2-percent annual increase. The average rate of increase in federal MediGrant funds is capped at 6.75 percent in fiscal 1997 and at 4 percent for fiscal years 1998–2002 [58]. The funding formula includes five different factors:

- The number of people in poverty
- A caseload cost index<sup>55</sup>
- The cost of care in a region

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55. The caseload cost index = [(national average costs for each beneficiary group) x (the number of state beneficiaries in that category)]/national average per Medicaid beneficiary.



- The U.S. average spending per person in poverty
- The federal-state matching rate.

The proposal ends the practice of reimbursing states for disproportionate share hospital payments but does include the federal DSH contribution in the baseline amount from which each state's grant is determined for FY 1996. Some governors and members of Congress argue that this unfairly rewards states that gamed the system in the past. Currently, 15 states receive the majority of all DSH payments, while others receive almost nothing [12].

### **Summary of Medicaid trends**

Medicaid has had a volatile history since its creation. The program has been modified in a number of ways since 1965, with eligibility criteria changes being turned on and off. At times, categories of people have been added to the list of mandatory coverage. At other times, the requirements have limited eligibility. As a result of all of these changes, as well as the general growth in medical costs, the general upward trend of growth in Medicaid spending has followed a uneven path, changing significantly from year to year in some cases. In addition, in recent years Medicaid has absorbed spending for some very high cost groups of eligibles: the elderly/disabled.

The current political climate (cutting budgets) is likely to be translated into changes for Medicaid. Experimentation with small Medicaid demonstration projects for alternative methods to deliver health care services is giving way to tentative plans to place most Medicaid recipients in managed care delivery systems. Block grants to the states will allow each state to devise and manage their own systems, with an overall theme to put Medicaid recipients into HMOs.

## **Trends and themes: Where are we going?**

Many changes are taking place in the provision of health care services, in both the public and the private sectors. Many efforts are under way to contain the growth of costs, but it is difficult to evaluate how successful these efforts will be in the long run. What lies behind the growth of our health care costs? The methods of delivery of health care, technological capabilities, demographics, and the sources of payment for health care expenditures have changed a great deal, and contribute to the growth in health care costs. Are there inefficiencies in how we provide health care? Is there a tendency to overutilize the health care system (e.g., unneeded tests)? Do we use more resources because our population is aging? Until we identify the factors that drive our rapidly increasing health care costs, it is difficult to know if the control measures being instituted will prove effective.

### **Government programs**

Although the health care system is changing rapidly, health care policy has evolved slowly in the United States. The federal government has remained fairly neutral with respect to regulating health care, except for Medicare and Medicaid. The original emphasis of these programs was to guarantee access to affordable health care for the elderly, disabled, and poor. As these programs have grown in terms of covered beneficiaries and expenditures, legislation has shifted to a more regulatory role. The trend throughout the 1980s was on regulatory cost-containment strategies, moving the federal government and the states to more micro-management, although this was not necessarily intended.

Starting in the 1990s, Congress shifted the vehicle of legislation from amendments to the Social Security Act to the budget reconciliation process [60]. Switching to the budget reconciliation process to pass

health care legislation affects policy-making procedure and the policies developed:

- Because of the need to find large budget savings, and because entitlement programs are the intended targets of reconciliation, it is relatively easier to change Medicare and Medicaid than to change discretionary spending.
- The Congressional subcommittees are the major players in the budget reconciliation process, which narrows the circle of involved actors and enhances the role of Congressional staff. Interest group access is constrained and the number of hearings are limited, resulting in less intense scrutiny of the implications of proposals.
- The executive/legislative relationship is different. Both the administration and Congress compete for credit for initiatives set forth in the legislation.

The net effect of using the reconciliation process focuses the legislative agenda on Medicare and Medicaid and reduces the opportunities for comprehensive reform. The current debate on Medicare and Medicaid is not about reforming the health care system; it is about balancing the federal budget, and many programs are under scrutiny.

Given the political power of the elderly, it is not clear how much Medicare will change. Transforming Medicaid will be much easier to achieve, probably by changing the funding mechanism for Medicaid from an entitlement with matching federal dollars to a lump sum block grant. However, the MediGrant process will be a challenge, because of a lack of experience at implementing and executing such a large block grant. Will states maintain current eligibility and coverage levels, particularly if program expenses significantly exceed the original funded amount?<sup>56</sup> In addition, although states believe they will be able to effectively use managed-care strategies to provide care to low-income persons, they lack experience in the actual execution of statewide managed-care programs.

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56. Proposed caps on federal rate increases are well below the CBO estimated rate of increase in Medicaid expenditures of 10 percent.

## The private sector

In the private sector, the focus is on cutting costs and utilization. The efforts to contain costs have been dealt with by three methods:

- Having insurers negotiate discounts with providers
- Instituting measures to make beneficiaries more sensitive to costs
- Turning to an increased reliance on managed-care programs.

The long-run effect of these measures on health care expenditures is uncertain at this time. We know that controlling costs in one arena often simply causes the costs to be shifted elsewhere, but we often lack data to let us determine the total impact. For one thing, we do not yet know how transferring cost consciousness to beneficiaries will ultimately affect the picture. Will beneficiaries just pay more out-of-pocket costs, so that total health care spending does not really slow down (which implies that the demand for health care services is inelastic)? Or, if beneficiaries do slow spending, because they do not feel able to pay for medical care (due to income constraints), will their health suffer?

Similarly, shifting inpatient care to ambulatory care for simple same-day surgery procedures decreases inpatient days per capita, but also increases outpatient costs. Because outpatient care is less costly than inpatient care, we expect this change to save money, although this depends on how much outpatient care grows. Consider the trend to keep mothers and infants in the hospital for only one night following childbirth. Will this save money, or will there be follow-on health problems that overshadow the savings? In general, are we holding quality constant, or are our changes yielding a loss of quality in health care services? If quality is declining, how minimal (or severe) is the loss?

At this time, there are no solid answers. Our evolving health care system and the increasing sophistication of health care services make it difficult to predict the effects of our current efforts to contain the upward spiral of health care costs. Our health care market is dynamic, and even as we learn more about its nature and how it operates, the

system changes. Changing technology explains some of the growth of our health care costs—we continue to find new, but often expensive, procedures to extend and improve life.

Another factor that makes it difficult to predict what will happen is the changing structure of our population. Our country is growing older in a relative sense, and our health care costs may climb as the baby-boomers age. Growing older is associated with more health care utilization. As a greater percentage of our population moves into the older age groups, we should expect more intensive utilization of relatively expensive health care services.

## Overall effort

The common thread between the major federal programs (Medicare and Medicaid) and the private insurance market is this: Both the federal government and private players have realized that health care cost increases are straining our economy. Federal costs are straining our ability to tax and pay for health care for the elderly, poor, and disabled, and private costs are straining employers' ability to provide health insurance to their employees and still offer decent wage increases. Both sectors are using cost-containment measures to try to slow the growth in health care spending by curtailing utilization. While we seem to be having some success in certain areas (e.g., hospitalizations), it is not clear whether we have brought the process under control in any long-term sense.

Our measures to control costs may work to increase the share of our population that has no health care coverage – a trend which appears to be growing [11, 12]. We do not yet know if there will be health implications or how this will affect health care spending in the long run.<sup>57</sup> Although we have begun to understand pieces of this puzzle, we do not have closure on the issues or solutions. Looking a decade ahead, we have not reached a consensus with regard to how to shape our health care system for the future.

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57. These issues are addressed at more length in [3].

## Appendix A: Services covered under Medicare, 1990

Table 2. Medicare, part A, covered services, 1990<sup>a</sup>

Type of covered service	Inpatient hospital	Skilled nursing facility	Home health agency	Hospice
Accommodations, semiprivate	x <sup>b</sup>	x	--	x
Blood transfusions	x	x	--	x
Counseling	—	—	—	x
Dental services requiring hospitalization	x	—	—	—
Doctors' services	—	—	—	x
Drugs and biologicals	x	x	—	x
Durable medical equipment	x	x	x	x
Emergency services	x	—	—	—
Home health aides	—	—	x	—
Homemakers' services	—	—	—	x
Intern and resident services, and teaching physicians in hospitals	x	x	x	—
Medical social services	x	x	x	x
Medical supplies and appliances	x	x	x	x
Nursing and related services, excluding private duty	x	x	—	x
Nursing, intermittent skilled nursing care	—	—	x	—
Occupational therapy	x	x	x	x
Other diagnostic services <sup>c</sup>	x	x	—	—
Outpatient services	—	x	x	—
Physical therapy	x	x	x	x
Respite care	—	—	—	x
Speech pathology	x	x	x	x
White blood and packed red blood cells	x	x	—	—

a. Source: [21].

b. x is covered; — is not covered.

c. Includes blood tests, X-rays, etc. [21].

Table 3. Medicare, part B, covered services, 1990<sup>a</sup>

Physician services	Outpatient services
Diagnostic tests and procedures	Ambulance transportation
Medical and surgical services, including anesthesia	Ambulatory surgical centers
Radiology and pathology services while a hospital inpatient or outpatient	Antigens and blood-clotting factors
Other services furnished in the doctor's office	Certified registered nurse anesthetist
X-rays	Clinic services
Drugs and biologicals	Comprehensive outpatient rehabilitation facility
Blood and blood components	Dialysis services
Medical supplies	Drugs and biologicals
Physical therapy	Durable medical equipment
Occupational therapy	Emergency room services
Speech therapy	Independent clinical laboratory
Chiropractic services (manual manipulation of the spine to correct subluxation)	Laboratory tests billed by hospital
Dental services that involve surgery on the jaw or the setting of fractures	Medical supplies
Optometrists, excluding routine eye examinations	Mental health services
Podiatrist services, excluding routine foot care	Nurse-midwife
Second opinions	Occupational therapy
	Physician assistant
	Portable diagnostic X-ray
	Prosthetic devices
	Psychologist services
	Rural health services
	Speech pathology
	Vaccines, hepatitis and pneumococcal
	X-rays and other radiology services billed by the hospital

a. Source: [21].

Table 4. Services not covered by Medicare, 1990<sup>a</sup>

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Acupuncture <sup>b</sup>
Chiropractic services
Christian Science practitioners
Cosmetic surgery <sup>b</sup>
Custodial care
Dental care <sup>b</sup>
Drugs and medicines purchased by enrollee with or without a doctor's prescription <sup>b</sup>
Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses <sup>b</sup>
Foot care that is routine <sup>b</sup>
Hearing aids and hearing examinations; fitting or changing hearing aids
Homemaker services
Immunizations, except hepatitis and pneumococcal injections that can be self-administered, such as insulin
Nursing homes
Meals delivered to enrollee's home
Naturopath's services
Nursing care on full-time basis in home of enrollee
Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge
Personal convenience items requested by enrollee (a phone or television in a hospital room or skilled nursing facility)
Physical examinations that are routine ( for example, yearly physical examinations) and tests directly related to such examinations
Private duty nurses
Private room <sup>b</sup>
Services performed by immediate relatives and members of enrollee's household
Services provided outside the United States <sup>1</sup>
Services that are not reasonable and necessary under Medicare program standards
Services payable by another government program

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a. Source: [21].

b. Items can be covered by Medicare under certain conditions.



## Appendix B: Medicaid trend data

Table 5. Medicaid medical assistance payments and administration expenditures, FY 1975–1993<sup>a</sup>

Fiscal year <sup>b</sup>	State reported expenditures				
	Current expenditures: HCFA Form 64, line 6				
	Total computable <sup>c</sup>	Amount	Federal share		State
			Percentage (in thousands)	Share	
1975	\$12,635,543		\$6,986,038	55.3	\$5,649,505
1976	14,641,774		8,109,360	55.4	6,532,414
1977	17,211,156		9,569,074	55.6	7,642,082
1978	19,136,864		10,578,607	55.3	8,558,257
1979	21,807,998		12,106,159	55.5	9,701,839
1980	25,221,795		13,987,330	55.5	11,234,465
1981	29,812,946		16,522,663	55.4	13,290,283
1982 <sup>d</sup>	31,797,537		17,614,406	55.4	14,183,131
1983 <sup>d</sup>	34,851,343		19,371,133	55.6	15,480,210
1984 <sup>d</sup>	37,311,446		20,653,977	55.4	16,657,469
1985	41,235,221		22,853,715	55.4	18,381,506
1986	44,512,468	24,824,095		55.8	19,688,373
1987	49,122,700	27,511,307		56.0	21,611,393
1988	54,073,380	30,450,896		56.3	23,622,484
1989	61,329,325		34,633,142	56.5	26,696,183
1990	72,920,339		41,369,626	56.7	31,550,713
1991	91,901,764		52,462,592	57.1	39,439,172
1992	118,176,825		67,942,878	57.5	50,233,947
1993	130,839,006		74,953,006	57.3	55,886,000
Percent change					
1975–1993	935.5		972.9	3.6	889.2

a. Source: [61].

b. Before 1976, the federal fiscal year was 1 June through 31 May; beginning 1 October 1976, the federal fiscal year became 1 October through 30 September. The data for the transition quarter (1 July through 30 September 1976) are omitted from this table.

c. Amounts do not include the expenditures for the State Survey and Certification and Fraud Control Unit.

d. Section 2161 OBRA 1981 reductions are not included.

Table 6. Number of Medicaid users by eligibility group: FY 1975–1993<sup>a</sup>

Year	Total	Low income				
		Children	Adult	Aged	Disabled	Other
			(in thousands)			
1975	22,007	9,598	4,529	3,615	2,464	1,801
1976	22,815	9,924	4,773	3,612	2,669	1,837
1977	22,832	9,651	4,785	3,636	2,802	1,958
1978	21,965	9,376	4,643	3,376	2,718	1,852
1979	21,520	9,106	4,570	3,364	2,753	1,727
1980	21,605	9,333	4,877	3,440	2,911	1,044
1981	21,980	9,581	5,187	3,367	3,079	766
1982	21,603	9,563	5,356	3,240	2,891	553
1983	21,554	9,535	5,592	3,372	2,921	134
1984	21,607	9,684	5,600	3,238	2,913	172
1985	21,814	9,757	5,518	3,061	3,012	466
1986	22,515	10,029	5,647	3,140	3,182	517
1987	23,109	10,168	5,599	3,224	3,381	737
1988	22,907	10,037	5,503	3,159	3,487	721
1989	23,511	10,318	5,717	3,132	3,590	754
1990	25,255	11,220	6,010	3,202	3,718	1,105
1991	27,967	12,855	6,703	3,341	4,033	1,035
1992	31,150	15,200	7,040	3,749	4,487	674
1993 <sup>b</sup>	33,432	16,285	7,505	3,863	5,016	763
		Percentage distribution				
1975	100.0	43.6	20.6	16.4	11.2	8.2
1976	100.0	43.5	20.9	15.8	11.7	8.1
1977	100.0	42.3	21.0	15.9	12.3	8.6
1978	100.0	42.7	21.1	15.4	12.4	8.4
1979	100.0	42.3	21.2	15.6	12.8	8.0
1980	100.0	43.2	22.6	15.9	13.5	4.8
1981	100.0	43.6	23.6	15.3	14.0	3.5
1982	100.0	44.3	24.8	15.0	13.4	2.6
1983	100.0	44.2	25.9	15.6	13.6	0.6
1984	100.0	44.8	25.9	15.0	13.5	0.8
1985	100.0	44.7	25.3	14.0	13.8	2.1
1986	100.0	44.5	25.1	13.9	14.1	2.3
1987	100.0	44.0	24.2	14.0	14.6	3.2
1988	100.0	43.8	24.0	13.8	15.2	3.1
1989	100.0	43.9	24.3	13.3	15.3	3.2
1990	100.0	44.4	23.8	12.7	14.7	4.4
1991	100.0	46.0	24.0	11.9	14.4	3.7
1992	100.0	48.8	22.6	12.0	14.4	2.2
1993 <sup>b</sup>	100.0	48.7	22.4	11.6	15.0	2.3

a. Source: [62].

b. 1993 data are from [63].

Table 7. Medicaid payments, by eligibility group: FY 1975–1992<sup>a</sup>

Year	Total	Low income				
		Children	Adult	Aged	Disabled	Other
		(in thousands)				
1975	\$12,242	\$2,186	\$2,062	\$4,358	\$3,145	\$ 491
1976	14,091	2,431	2,288	4,910	3,920	542
1977	16,239	2,610	2,606	5,499	4,883	641
1978	17,992	2,748	2,673	6,308	5,620	643
1979	20,472	2,884	3,021	7,046	6,882	639
1980	23,311	3,123	3,231	8,739	7,621	597
1981	27,204	3,508	3,763	9,926	9,455	552
1982	29,399	3,473	4,093	10,739	10,405	689
1983	32,391	3,836	4,487	11,954	11,367	747
1984	33,891	3,979	4,420	12,815	11,977	700
1985	37,508	4,414	4,746	14,096	13,452	800
1986	41,005	5,135	4,880	15,097	14,913	980
1987	45,050	5,508	5,592	16,037	16,817	1,096
1988	48,710	5,848	5,883	17,135	18,594	1,250
1989	54,500	6,892	6,897	18,558	20,885	1,268
1990	64,859	9,100	8,590	21,508	24,404	1,257
1991	76,964	11,600	10,421	25,444	28,251	1,248
1992	91,480	14,758	12,403	29,089	34,004	1,226
1993 <sup>b</sup>	101,709	16,504	13,605	31,554	38,655	1,391
Percentage distribution						
1975	100.0	17.9	16.8	35.6	25.7	4.0
1976	100.0	17.3	16.2	34.8	27.8	3.8
1977	100.0	16.1	16.0	33.9	30.1	3.9
1978	100.0	15.3	14.9	35.1	31.2	3.6
1979	100.0	14.1	14.8	34.4	33.6	3.1
1980	100.0	13.4	13.9	37.5	32.7	2.6
1981	100.0	12.9	13.8	36.5	34.8	2.0
1982	100.0	11.8	13.9	36.5	35.4	2.3
1983	100.0	11.8	13.9	36.9	35.1	2.3
1984	100.0	11.7	13.0	37.8	35.3	2.1
1985	100.0	11.8	12.7	37.6	35.9	2.1
1986	100.0	12.5	11.9	36.8	36.4	2.4
1987	100.0	12.2	12.4	35.6	37.3	2.4
1988	100.0	12.0	12.1	35.2	38.2	2.6
1989	100.0	12.6	12.7	34.1	38.3	2.3
1990	100.0	14.0	13.2	33.2	37.6	1.9
1991	100.0	15.1	13.5	33.1	36.7	1.6
1992	100.0	16.1	13.6	31.8	37.2	1.3
1993 <sup>b</sup>	100.0	16.2	13.4	31.0	38.0	1.4

a. Source: [62].

b. 1993 data are from [63].

## Appendix C: Medicaid eligibility reform

Table 8. Major eligibility reforms under Medicaid, 1984 through 1990<sup>a</sup>

Medicaid reform	Relevant legislation
Mandated coverage of single pregnant women, pregnant women in two-parent unemployed families, and all children under age 5 born after 30 Sept 1983 with AFDC-level income. Increased upper-level on AFDC gross-income test from 150% to 185%.	Deficit Reduction Act of 1984, P.L. 98-369
Mandated coverage of all remaining pregnant women with family incomes below AFDC eligibility levels and immediate coverage of all children under age 5 with AFDC-level income	Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272
Optional coverage of all pregnant women and children born after 30 Sept 1983 with family incomes not exceeding 100% of poverty and with family assets below state-set levels	Omnibus Budget Reconciliation Act of 1986, P.L. 99-509
Optional coverage of pregnant women and infants with family incomes not exceeding 185% of poverty and family assets not exceeding state-set levels	Omnibus Budget Reconciliation Act of 1987, P.L. 100-203
Mandated coverage of all pregnant women and infants with family incomes below 100 percent of poverty; option to use more liberal standards and methodologies	Medicare Catastrophic Coverage Act of 1988, P.L. 100-360
Mandated coverage of all pregnant women and children under age 6 with family incomes below 133 percent of poverty	Omnibus Budget Reconciliation Act of 1989, P.L. 101-239
Mandated coverage of all poverty level children under age 19 born after 30 Sept 1983 who have attained age 6 and with incomes up to 100% of poverty. Mandates continuous benefits for women throughout pregnancy and for infants born to Medicaid women up to the age of 1	Omnibus Budget Reconciliation Act of 1990, P.L. 101-508

a. Source: [64].

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